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UNUM LIFE INSURANCE COMPANY
OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

E-FILING

SHERI GARAY,

Plaintiff,

vs.

UNUM LIFE INSURANCE COMPANY OF AMERICA, and DOES 1-10,

Defendants.

CASE NO. **3:08-cv-01059 SBA**

DEFENDANTS' NOTICE OF MOTION AND MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE APPLICABILITY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Date July 22, 2008
Time: 1:00 p.m.
Ctrm: 3

The Honorable Saundra Brown Armstrong

TO PLAINTIFF AND HER ATTORNEYS OF RECORD:

NOTICE IS HEREBY GIVEN that on July 22, 2008 at 1:00 p.m. in Courtroom 3 of the above-entitled Court, located at 1301 Clay Street, Oakland, California, Defendant UNUM LIFE INSURANCE COMPANY OF AMERICA ("UNUM"), will and hereby does move this Court for an Order for Partial Summary Judgment: (1) affirming that the insurance policy at issue is governed by the Employee Retirement Income Securities Act ("ERISA"); (2) affirming that plaintiff's causes of action and remedies are limited to those available under ERISA; and (3) dismissing plaintiff's

preempted state law causes of action, preempted prayers for extra-contractual relief, and preempted prayer for a trial by jury.

This Motion for Partial Summary Judgment is made on the grounds that a benefits plan that covers one or more employees in addition to the business owner, such as the one at issue here, is governed by ERISA, and that ERISA provides the exclusive remedy available to plaintiff, all other remedies and causes of action being preempted.

Counsel for defendant hereby certifies that counsel for both parties met and conferred regarding the filing of defendant's motion for partial summary judgment at the same time they met and conferred on the Case Management Conference Statement. At the Case Management Conference, counsel further discussed the filing of this motion, and the Court instructed this motion be filed on June 17, 2008, and set the motion hearing for July 22, 2008.

This motion is based on this Notice of Motion and Motion, the Memorandum of Points and Authorities in support of this motion, the Declaration of Anna M. Stein and Exhibits attached thereto, and on such other and further oral and documentary evidence as may be presented at the hearing of this motion.

Respectfully submitted,

RIMAC & MARTIN, P.C.

DATED: June 17, 2008

By: /s/ ANNA M. MARTIN
ANNA M. MARTIN
Attorneys for Defendants
UNUM LIFE INSURANCE COMPANY OF AMERICA

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I. INTRODUCTION

On October 2, 1995, plaintiff Sheri Garay, doing business as Site For Sore Eyes, executed an *Application for Participation in the Select Group Insurance Trust* ("Application") offered by UNUM Life Insurance Company of America. (Decl. of Anna Stein, Exh. A, UACL1206). By that Application, plaintiff made clear she was seeking "Group Long Term Disability Benefits" coverage for her business's eligible employees. (*Id*.) The only persons eligible to obtain said coverage were "all employees of each participating employer." (*Id.*, at UACL01201). The cost of insurance is paid by the owner/employer. (*Id*.) The Plan plaintiff obtained even warned that the insurer (Unum) could cancel coverage if the number of covered employees ever dropped below two. (*Id*., at UACL01205.)

Any benefits plan that is "*established* or maintained by an employer . . . for the purpose of providing [disability insurance] for its participants or their beneficiaries," is governed by ERISA. 29 U.S.C. § 1002(1). Thus, ERISA governs the Group Long Term Disability Benefits Plan (the "Plan") that plaintiff both established and maintained for her Site For Sore Eyes employees, and under which she filed the claim at issue in this lawsuit. Correspondingly, plaintiff's remedies are limited to those available under ERISA. ERISA also limits discovery and precludes a jury trial.

Given that a determination that ERISA governs the Plan will substantially alter the arc of this matter, reduce party expenditures and preserve judicial resources, UNUM respectfully requests that the Court grant summary adjudication as to the applicability of ERISA, and dismiss the unavailable claims and remedies plaintiff seeks.

II. STATEMENT OF FACTS

A. PLAINTIFF APPLIES FOR A GROUP LONG TERM DISABILITY BENEFITS PLAN TO COVER THE ELIGIBLE EMPLOYEES OF HER BUSINESS, SITE FOR SORE EYES.

On October 2, 1995, plaintiff Sheri Garay executed an an *Application for Participation in the Select Group Insurance Trust* ("Application") which provided in pertinent part:

> To: The Trustee(s) of The Select Group Insurance Trust and UNUM Life Insurance Company of America
>
> Name of Employer/Applicant: *Sheri A. Garay dba Site For Sore Eyes*

> . . . requests approval to participate in the above named Insurance and for its eligible employees under the terms of the group policy(ies) issued to the Trustee(s) of the Trust for the following coverage(s):
>
> . . . Group Long Term Disability Benefits
>
> By this application, the Employer/Applicant:
> 1. agrees and accepts the terms of the Trust Agreement (including all amendments to the Trust Agreement) for the Insurance Trust named above for so long as it elects to participate in the Trust:
> 2. agrees to remit regularly the required premium payments; and
> 3. elects coverage as shown in the Summary of Benefits and agrees that only those provisions which appear in the Summary of Benefits provided to the Employer/Applicant apply to its insurance coverage.
>
> Dated at *Concord, CA*
> By (Employer/Applicant) [*signature of Sheri Garay*]
> on *10-2-95* By [*signature of agent/broker*]

(Decl. Stein, Exh. A, at UACL01206). Thus it was clear from the outset that plaintiff was acting as an employer, seeking to establish a plan for group long term disability benefits. (*Id.*)

B. THE PLAN MAKES CLEAR THAT THE "EMPLOYER" IS THE CLIENT, AND THAT ACTIVE EMPLOYEES ARE THE ONLY ELIGIBLE PARTICIPANTS

In reliance on plaintiff's Application, UNUM issued Group Long Term Disability Benefits Plan, Group Identification No. 108121 (the "Plan"), to Site for Sore Eyes.

The Plan itself makes clear that it is the "employer" that is the client:

> CERTIFICATE OF COVERAGE
>
> Unum Life Insurance Company of America . . . welcomes your employer as a client.

(Decl. Stein, Exh. A, at UACL00072).

The Plan confirms that the sole participating employer is "Site For Sore Eyes," and describes the eligible class of participants as follows:

> • DESCRIPTION OF ELIGIBLE CLASSES
>
> All employees of each participating employer.

(*Id.*, at UACL01201). The Plain is thus only available to employees of Site For Sore Eyes.

The Plan describes what entity pays for contributions to the Plan as follows:

> • CONTRIBUTIONS

For Partners or Sole Proprietors
- The cost of your insurance is paid by you.

For All Others
- The cost of your insurance is paid entirely by your employer.

(Decl. Stein, Exh. A, at UACL01202).

The Plan contains the following pertinent definitions:

TERMS YOU SHOULD KNOW

Many terms used in your certificate of coverage have special meanings. A list of these terms and meanings follows:

- "**Active employment**" means you must be working:

  1. for your employer on a full-time basis and paid regular earnings (temporary or seasonal employees are excluded);
  2. at least the minimum number of hours shown in the summary of benefits; and either
  3. at your employer's usual place of business; or
  4. at a location to which your employer's business requires you to travel.

- "**Basic monthly earnings**" - if you are:

  1. a Partner, means your average monthly earnings as figured:
     a. from the line which shows "net earnings (loss) from self-employment" from schedule K-1 of the partnership federal income tax return for the tax year just prior to the date disability begins; or
     b. for the period that you have been a partner if you were not a partner during the year for which the most recent partnership federal income tax return was filed.

  2. a Sole Proprietor, means your annual net profit averaged over:
     a. the 3 most recent years; or
     b. the period that you have been a sole proprietor, if you have been a sole proprietor for less than 3 years,

     then divided by 12.

     Annual net profit is figured on form 1040 Schedule C as the gross income less total deductions minus depreciation.

  3. an employee other than Partners or Sole Proprietors, means your average monthly earnings as figured:

a. from the W-2 form (from the box which reflects wages, tips and other compensation) received from the employer for the calendar year just prior to the date disability begins; or

b. for the period of employment if no W-2 form was received.

. . .

• "**Employer**" means a proprietorship, partnership or corporation which becomes a participating employer by completing an application for participation and having the application approved by the Company and the trustees of the fund.

(Decl. Stein, Exh. A, at UACL00074-75.)

Thus, the Plan makes clear that the only persons eligible to participate in the coverage offered by the Plan are "active" employees of Site For Sore Eyes:

ENROLLMENT AND DATE INSURANCE STARTS

When can you enroll?
You can enroll if you are:
1. in active employment with your employer; and
2. in a class eligible for insurance.

(*Id*., at UACL00077.) Further, the Plan warns that coverage can be terminated if the number of covered employees ever falls below two.

C. AT ITS INCEPTION, THE PLAN COVERED FOUR EMPLOYEES, INCLUDING PLAINTIFF AS A WORKING OWNER.

A *Long Term Disability Mini-Plan Proposal* dated October 6, 1995, shows that plaintiff was seeking long term disability benefits coverage for herself and three other employees:

	First Name	Last Name	. . .	Occupation
1.	SHERRI	A[*****]	. . .	SALES
2.	WAYNE	C[*******]	. . .	LAB TECH
3.	SHERI	GARAY	. . .	OWNER-SALES
4.	STACY	S[*****]	. . .	SALES
. . .				
TOTAL MONTLY LTD PREMIUM				$110.83

(Decl. Stein, Exh. B; see also Exh. C, *Mini-Plan Benefits & Cost Summary*, at 3.) Plaintiff thus represented herself as a working owner, who would thereby be entitled to participate in the Plan.

Plaintiff's business, Site For Sore Eyes, paid the initial premium for the period from October

1, 1995 to October 31, 1995, and Unum subsequently issued the Group Long Term Disability Benefits Plan, Identification No. 108121, to Site For Sore Eyes, Inc. (The "Plan") with an effective date of October 1, 1995. (Decl. Stein, ¶ 7.) The Plan initially covered Sheri Garay and three employees of Site For Sore Eyes, including non-owner employee Sherri A. (*Id*., at ¶¶ 7, 8.)

D. AT THE TIME PLAINTIFF APPLIED FOR BENEFITS, THE PLAN STILL COVERED MULTIPLE EMPLOYEES

Plaintiff submitted a Disability Claim form seeking coverage under the Plan on or about June 13, 2002. (Decl. Stein, Exh. QQ.) When plaintiff applied for disability benefits, she claimed entitlement to disability benefits precisely because she was a working owner. (*Id*., at UACL00017 (listing plaintiff's duties as "Sales"); UACL00020 (listing plaintiff's job title as "Optician").)

A *Group Insurance Premium Statement* for Plan No. 0108121, dated February 7, 2003, names six employees, including plaintiff. (Decl. Stein, Exh. LL.) That document shows that employee Sherri A. was still employed at plaintiff's Site For Sore Eyes, and was still a participant in the Plan. In fact, employee Sherri A. was a plan participant from the Plan's inception through the time plaintiff sold her business to new owners in 2004. (Decl. Stein, ¶ 8.)

E. AT NO TIME BETWEEN THE ESTABLISHMENT OF THE PLAN AND THE DATE PLAINTIFF SOLD HER BUSINESS DID THE PLAN EVER COVER LESS THAN TWO EMPLOYEES

On January 9, 2004, Sheri Garay sold her Site For Sore Eyes business to New Age Optical, Inc. (Decl. Stein, Exh. RR.)

Between the inception of the Plan and the date the business was sold to new owners, Site For Sore Eyes repeatedly added and subtracted employees from participation in the Plan. (*Id*., ¶¶ 7, 8, Exhs. E – PP). **Never** did the number of employee participants fall below two. (*Id*.) In addition to plaintiff Sheri Garay, non-owner, employee Sherri A. was a Plan participant from inception through the date plaintiff sold her business to new owners. (Id. at ¶ 8.)

Thus, from its inception, the Plan was both established and maintained by plaintiff's business to cover both plaintiff, as a working owner, and at least one other employee. The number of employee participants never fell below two.

III. LEGAL STANDARDS

A. SUMMARY JUDGMENT

Summary judgment is appropriate where "there is no genuine issue as to any material fact" and "the moving party is entitled to a judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the initial burden of identifying relevant portions of the record that demonstrate the absence of a fact or facts necessary for one or more essential elements of each cause of action upon which the moving party seeks judgment. *See Celotex Corp. v. Catrett,* 477 U.S. 317, 323 (1986).

If the moving party sustains its burden, the nonmoving party must then identify specific facts, drawn from materials on file, that demonstrate that there is a dispute as to material facts on the elements that the moving party has contested. *See* Fed.R.Civ.P. 56(c). The nonmoving party must not simply rely on the pleadings and must do more than make conclusory allegations in an affidavit. *Lujan v. National Wildlife Fed'n,* 497 U.S. 871, 888 (1990). Summary judgment must be granted for the moving party if the nonmoving party "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex.* at 322.

In light of the facts presented by the nonmoving party, along with any undisputed facts, the Court must decide whether the moving party is entitled to judgment as a matter of law. *See T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Ass'n*, 809 F.2d 626, 631 n. 3 (9th Cir.1987). "[T]he inferences to be drawn from the underlying facts . . . must be viewed in the light most favorable to the party opposing the motion." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 587 (1986). Summary judgment for the moving party is proper when a rational trier of fact would not be able to find for the nonmoving party on the claim or claims at issue. *Id.*

Where a case "is not fully adjudicated by a motion for summary judgment, the court is empowered to grant summary adjudication as to specific issues if it will narrow the issues for trial." *Bernstein v. Travelers Ins. Co.*, 2006 WL 2567875, *2 (N.D.Cal., Sept. 5, 2006) (*citing* Fed.R.Civ.P. 56(d)); *see Robi v. Five Platters, Inc.*, 918 F.2d 1439, 1441-42 (9th Cir. 1990).

/ / /

/ / /

B. ERISA APPLICABILITY

"The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." *Kanne v. Conn. Gen. Life Ins.*, 867 F.2d 489, 492 (9th Cir.1988). "A policy is governed by ERISA if it is '*established* or maintained by an employer . . . for the purpose of providing [disability insurance] for its participants or their beneficiaries.'" *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 408 (9th Cir. 1995) (quoting 29 U.S.C. § 1002(1)).

A plan whose sole beneficiary is the company's owner does not qualify as a plan under ERISA. *Kennedy v. Allied Mut. Ins. Co.*, 952 F.2d 262, 264 (9th Cir.1991). However, if the plan covers one or more employees in addition to than the business owner, the plan is governed by ERISA. *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* 541 U.S. 1, 6 (2004). Further, if the plan was "established" (i.e. originally purchased) for the purpose of providing benefits to employees as well as the business owner, the policy is governed by ERISA even if the number of non-owner employee participants subsequently drops to zero. *See Peterson*, 48 F.3d at 408.

IV. ARGUMENT

In October 1995, plaintiff Sheri Garay established a Group Long Term Disability Benefits plan with UNUM on behalf of her business, Site For Sore Eyes, to cover its employees. (Decl. Stein, Exh. A, at UACL01206). Plaintiff did not seek an individual policy, but rather a group plan, which would cover all eligible employees of her business, including herself. (*Id.*) In addition to plaintiff, at least one non-owner employee was a Plan participant for the entire time the Plan covered plaintiff's business. (*Id.*, at ¶¶ 7, 8.)

A group plan such as the Plan plaintiff obtained "qualifies for the protections ERISA affords . . . and is governed by the rights and remedies ERISA specifies." *Yates*, 541 U.S. at 6.

Correspondingly, UNUM respectfully requests that the Court grant partial summary judgment, affirm that the Plan at issue is governed by ERISA, and hold that plaintiff's potential remedies are limited to those provided by ERISA.

/ / /

A. THE GROUP LONG TERM DISABILITY PLAN AT ISSUE IN THIS ACTION IS GOVERNED BY ERISA.

The Plan at issue in the Complaint, which plaintiff established with UNUM on behalf of her business, Site For Sore Eyes, in 1995, was a Group Long Term Disability Plan, which covered the business's eligible, "active" employees. As a group plan established to cover, and covering, Site For Sore Eye's employees (including plaintiff as a working owner), the Plan is governed by ERISA, and plaintiff's remedies are thus circumscribed by ERISA.

While it is true that a benefit plan that, from the outset, covers only a sole business owner is not an employee benefit plan under ERISA, a plan that covers working owners and at least one nonowner employee, "fall[s] entirely within ERISA's compass." *Yates*, 541 U.S. at 21. Additionally, if a plan was "established" (i.e. originally purchased) or maintained for the purpose of providing benefits to employees as well as the business owner, the policy is governed by ERISA even if the number of non-owner employee participants subsequently drops to zero. *See Peterson*, 48 F.3d at 408

The Plan here unquestionably was established to cover, and has covered, both plaintiff as working owner and plaintiff's nonowner employees. Plaintiff sought and obtained group long term disability coverage, not individual coverage. The Plan plaintiff obtained for her business covered four employees (including plaintiff) at the outset of coverage. (Decl. Stein, ¶ 7.) Plaintiff maintained the Plan to cover both herself and a number of employees, and repeatedly added and terminated coverage for her various employees during the time between establishment of th eplan and the sale of the business. (*See Id.*, ¶¶ 7, 8, Exhs. E – PP.) At no time did the number of non-owner employee participants drop to zero. (*See Id*.) The Plan is governed by ERISA.

B. PLAINTIFF'S CAUSES OF ACTION AND REMEDIES ARE LIMITED TO THOSE AVAILABLE UNDER ERISA.

Plaintiff's Complaint contains three causes of action: (1) breach of contract; (2) declaratory relief; and (3) breach of the implied covenant of good faith and fair dealing. The Complaint also seeks a trial by jury and a number of remedies, including general damages for emotional distress, punitive damages, compensation for purportedly improperly withheld taxes, and compensation for

unidentified "financial injury." Plaintiff's causes of action and prayer for extra-contractual, non-benefit remedies are preempted by ERISA. Because the Plan is governed by ERISA, plaintiff's sole remedy, as provided for in 29 U.S.C. § 1132, is a " civil action . . . to recover benefits due" to plaintiff, if any, under the terms of the Plan.

"There are two strands to ERISA's powerful preemptive force. First, ERISA section 514(a) expressly preempts all state laws 'insofar as they may now or hereafter relate to any employee benefit plan,'" though state laws which regulate insurance, banking, or securities are saved from this preemption. *Cleghorn v. Blue Shield of California,* 408 F.3d 1222, 1225 (9th Cir. 2005) (*quoting* 29 U.S.C. §§ 1144(a), (b)(2)(A)).

"Second, ERISA section 502(a) contains a comprehensive scheme of civil remedies to enforce ERISA's provisions." *Id.* (*citing* 29 U.S.C. § 1132(a)). Section 502(a) of ERISA provides, among other things, that "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan . . . ." 29 U.S.C. § 1132(a). Thus, a "state cause of action that would fall within the scope of this scheme of remedies is preempted as conflicting with the intended exclusivity of the ERISA remedial scheme, even if those causes of action would not necessarily be preempted by section 514(a)." *Cleghorn*, 408 F.3d at 1225 (*citing Aetna Health Inc. v. Davila,* 542 U.S. 200, 214, n. 4 (2004)).

Because the Plan here is governed by ERISA, plaintiff's sole available cause of action is a " civil action . . . to recover benefits due" under the terms of the Plan. 29 U.S.C. § 1132. Plaintiff's state law causes of action and prayer for extra-contractual remedies are preempted.

Additionally, "there is no right to a jury trial in ERISA cases." *Ingram v. Martin Marietta Long Term Disability Income Plan for Salaried Employees of Transferred GE Operations*, 244 F.3d 1109, 1114 (9th Cir. 2001). Rather, "[d]epending upon the language of an ERISA plan, a district court reviews a plan administrator's decision to deny benefits either *de novo* or for abuse of discretion." *Id.*, at 1112.

Plaintiff both established and maintained a group long term disability benefits plan from UNUM in 1995, to cover the employees of her business, Site For Sore Eyes, including herself. Plaintiff obtained the benefits and protections offered by ERISA to group benefit plans, but now

seeks to escape ERISA and pursue otherwise unavailable causes of action seeing otherwise unavailable remedies. UNUM respectfully requests that the Court grant its motion for partial summary judgment, and affirm that the Plan is governed by ERISA, that plaintiff's sole available remedy is through ERISA, where a jury trial is unavailable, and dismiss plaintiff's state law causes of action and prayers for extra-contractual remedies.

V. CONCLUSION

For the foregoing reasons, Unum respectfully requests that the Court grant its motion for partial summary judgment, confirm that the insurance policy at issue is governed by ERISA, and find that plaintiff's sole available cause of action is a " civil action . . . to recover benefits due" under the terms of the Plan, where a trial by jury and extra-contractual damages are unavailable.

Respectfully submitted,

RIMAC & MARTIN, P.C.

DATED: June 17, 2008

By: /s/ ANNA M. MARTIN
ANNA M. MARTIN
Attorneys for Defendant
UNUM LIFE INSURANCE COMPANY OF AMERICA

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UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

E-FILING

SHERI GARAY, Plaintiff, vs. UNUM LIFE INSURANCE COMPANY OF AMERICA, and DOES 1-10, Defendants.	CASE NO. **3:08-cv-01059 SBA** **DECLARATION OF ANNA M. STEIN IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE APPLICABILITY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)** Date July 22, 2008 Time: 1:00 p.m. Ctrm: 3 The Honorable Saundra Brown Armstrong

I, Anna M. Stein, hereby declare as follows:

1. I am an Assistant Vice President, Regional Operations, Client Service Center for defendant UNUM LIFE INSURANCE COMPANY OF AMERICA (" UNUM"). As a result, I am responsible for all Group Core Market, less than 2000 lives, business for UNUM U.S. My responsibilities include the following:

* Overseeing billing functions;

* Overseeing new business functions, including the issuance of

contracts and initial customer deliverables for non standard Home Office issued business; and,

* Overseeing the premium collection and accounting functions.

2. In my capacity as Assistant Vice President, Regional Operations, Client Service Center, I have personal knowledge of the proposal provided for the issuance of Long Term Disability Coverage to the employee group, Site For Sore Eyes, the premiums billed and collected for the Long Term Disability Coverage issued to Site For Sore Eyes, and the employees insured by the Site For Sore Eyes Long Term Disability Coverage, Group Identification Number 108121. I have personal knowledge of all the matters stated herein, and, if called to testify, I could competently do so.

3. I also have personal knowledge of UNUM's practices and procedures for maintaining records in the ordinary course of business. It was and currently is the ordinary course of business for UNUM to maintain records relative to group disability insurance, such as the exhibits attached hereto, which records were made at or near the time of the acts, transactions, occurrences, and/or events reflected in the records, or within a reasonable time thereafter, by someone with personal knowledge of such acts, transactions, occurrences, and/or events.

4. Attached as "**Exhibit A**" is a true and correct copy of the *Group Long Term Disability Benefits Plan,* Identification No. 108121, issued to Site For Sore Eyes, Inc.

5. Attached as "**Exhibit B**" is a true and correct copy of the *Long Term Disability Mini-Plan Proposal* dated October 6, 1995 which was prepared for Sheri Garay and Site For Sore Eyes, Inc.. Ms. Garay was the sole owner of Site For Sore Eyes a franchise doing business as New Age Optical, Inc.. The Mini Plan Proposal demonstrates that Ms. Garay was seeking long term group disability coverage for herself and at least one other non-owner, employee.

6. Attached as "**Exhibit C**" is a true and correct copy of the *Mini-Plan Benefits & Cost Summary*, prepared for Sheri Garay and Site For Sore Eyes, Inc., which demonstrates that Ms. Garay was seeking to obtain long term group disability coverage for herself and at least one other employee.

7. Attached as "**Exhibit D**" is a true and correct copy of the *Select Risk Questionnaire* signed by Ms. Garay as owner of Site For Sore Eyes, dated October 2, 1995.

8. The initial premium was paid for the period from October 1, 1995 to October 31, 1995 by Site For Sore Eyes and UNUM issued the Group Long Term Disability Benefits Plan, Identification No. 108121, to Site For Sore Eyes, Inc. (The "Plan") with an effective date of October 1, 1995. The Plan initially covered Sheri Garay and three employees of Site For Sore Eyes. The three other employees were not owners of the business Site For Sore Eyes. Ms. Garay established the Plan by arranging for the issuance of the Plan to Site For Sore Eyes to provide disability insurance to Ms. Garay and the eligible employees of Site For Sore Eyes. Moreover, Ms. Garay maintained the Plan by making all premium payments for herself and the eligible non-owner employees of Site For Sore Eyes.

9. The Plan remained in effect covering the employees of Site For Sore Eyes, with Sheri Garay as sole owner, until Site For Sore Eyes was sold to new owners in January, 2004. From the inception of the Plan on October 1, 1995 through January, 2004 (when Site For Sore Eyes was sold to new owners), the Plan continuously insured at least one other non-owner employee. In fact, the Plan continuously insured two other non-owner employees from October 1, 1995 through January, 2004. At no time was plaintiff Sheri Garay the sole plan participant. For example, non-owner, employee Sherri A. was a Plan participant from October 1, 1995 (the inception of the Plan) through the date of her termination of employment on March 20, 2004, which was after Site For Sore Eyes was sold to new owners. Moreover, as demonstrated below, Site For Sore Eyes repeatedly added and subtracted employees as participants under the Plan.

10. Attached as "**Exhibit E**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of December 1, 1995 for the Plan. The premium statement also indicates the amount of premium owed, and as yet unpaid, for the period of November 1, 1995 to November 30, 1995. This document demonstrates that the Plan insured Sheri Garay and at least one other non-owner, employee at its inception.

11. Attached as "**Exhibit F**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of January 1, 1996 for the Plan. The premium statement also

included the amount of premium owing for the periods of November 1, 1995 to November 30, 1995 and December 1, 1995 to December 31, 1995. The total premium in the amount of $337.56 was paid and collected by UNUM. This document demonstrates that the Plan continued to insure Sheri Garay and at least one other non-owner, employee.

12. Attached as "**Exhibit G**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of February 1, 1996. Premium was paid for the period February 1, 1996 in which Sheri Garay and at least one other non-owner employee were insured under the Plan.

13. Attached as "**Exhibit H**" is a true and correct copy of the *Group Insurance Premium Statement* with due date from March 1, 1996. This document demonstrates that multiple employees were insured under the Plan. Premiums were paid for the periods March 1, 1996 through September 30, 1996 in which Sheri Garay and at least one other non-owner employee were insured under the Plan.

14. Attached as "**Exhibit I**" is a true and correct copy of the *Group Insurance Premium Statement* with due date of October 1, 1996. This document demonstrates that one employee was terminated and thus no longer insured under the Plan. Premiums were paid for the period October 1, 1996 through November 30, 1996. This document demonstrates that the Plan continued to insure Sheri Garay and at least one other non-owner, employee.

15. Attached as "**Exhibit J**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of December 1, 1996. Premium was paid for the period December 1, 1996 through December 31, 1996, during which time the Plan continued to insure Sheri Garay and at least one other non-owner employee.

16. Attached as "**Exhibit K**" are true and correct copies of the *Group Insurance Premium Statements* with due dates of January 1, 1997 and February 1, 1997. Premiums were paid for the period January 1, 1997 through February 28, 1997, during which time the Plan continued to insure Sheri Garay and at least one other non-owner employee.

17. Attached as "**Exhibit L**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of March 1, 1997. This document demonstrates that multiple

employees were insured the Plan. Premium was paid for the period March 1, 1997 through January 31, 1998, during which time the Plan insured Sheri Garay and four other non-owner, employees.

18. Attached as "**Exhibit M**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of February 1, 1998 through April 1, 1998. These documents demonstrate, among other things, that two additional employees were added as insureds under the Plan effective February 1, 1998. Premiums were paid for the period February 1, 1998 through May 31, 1998, during which time the Plan insured Sheri Garay and six other non-owner, employees.

19. Attached as "**Exhibit N**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of June 1, 1998 through October 1, 1998. These documents demonstrate that two employees were terminated effective June 1, 1998. Premiums were paid for the period June 1, 1998 through October 31, 1998, during which time the Plan insured Sheri Garay and four other non-owner, employees.

20. Attached as "**Exhibit O**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of November 1, 1998 and the corresponding premium check from Site For Sore Eyes. These document demonstrate that an employee was terminated effective October 26, 1998 and thus, no longer insured under the Plan. Premium was paid for the period November 1, 1998 through November 30, 1998, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

21. Attached as "**Exhibit P**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of December 1, 1998, the Group Enrollment Form for a new employee, and checks for premiums paid in December 1998 by Site For Sore Eyes. This document demonstrates that an employee was terminated effective November 18, 1998 and thus, no longer insured under the Plan. Premium was paid for the period December 1, 1998 through December 31, 1998, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

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22. Attached as "**Exhibit Q**" is a true and correct copy of the *Group Insurance Premium Statement* with a due date of January 1, 1999. The document demonstrates that two employees were terminated effective November 30, 1998 and December 13, 1998 and thus, no longer insured under the Plan. This document further demonstrates that an employee of Site For Sore Eyes was added as an insured. Premium was paid for the period January 1, 1999 through January 31, 1999, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

23. Attached as "**Exhibit R**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of February 1, 1999 through June 1, 1999, two Group Enrollment forms for adding new employees to the plan, and checks for premiums paid. These documents demonstrate that two employees were added as insureds under the Plan. Premium was paid for the period February 1, 1999 through June 1, 1999, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

24. Attached as "**Exhibit S**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of July 1, 1999, a Group Enrollment Form for the addition of a new employee, and a premium check. These documents demonstrate that an employee was added as an insured under the Plan.

25. Attached as "**Exhibit T**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of August 1, 1999 and a premium check. These documents demonstrate one employee was terminated effective July 31, 1999 and thus, no longer insured under the Plan. This document further demonstrates that an employee of Site For Sore Eyes was added as an insured effective August 1, 1999.

26. Attached as "**Exhibit U**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of September 1, 1999 through February 1, 2000, Group Enrollment Forms for new employees, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective August 24, 1999 and thus, no longer insured under the Plan. Premium was paid for the period July 1, 1999 through February 29,

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2000, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

27. Attached as "**Exhibit V**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of March 1, 2000 through May 1, 2000. These documents demonstrate that an employee of Site For Sore Eyes was added as an insured effective February 1, 2000. Premium was paid for the period March 1, 2000 through May 31, 2000, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

28. Attached as "**Exhibit W**" are true and correct copies of the *Group Insurance Premium Statements* with a due date of June 1, 2000, a Group Enrollment Form, and a premium check. The two page statement demonstrates that an employee of Site For Sore Eyes was added as an insured under the Plan effective May 4, 2000.

29. Attached as "**Exhibit X**" are true and correct copy of the *Group Insurance Premium Statement* with a due date of July 1, 2000, a Notice of Address Change, and one premium check. This statement demonstrates that an employee of Site For Sore Eyes was terminated effective June 8, 2000 and thus, no longer insured under the Plan.

30. Attached as "**Exhibit Y**" is a true and correct copies of the *Group Insurance Premium Statements* with due dates of August 1, 2000 and September 1, 2000, a Group Enrollment Form for a new employee, and premium checks. These document s demonstrate that an employee of Site For Sore Eyes was added as an insured under the Plan effective August 1, 2000.

31. Attached as "**Exhibit Z**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of October 1, 2000 and November 1, 2000, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective September 30, 2000 and thus, no longer insured under the Plan.

32. Attached as "**Exhibit AA**" is a true and correct copies of the *Group Insurance Premium Statements* with due dates of December 1, 2000 and January 1, 2001, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective September 28, 2000 and thus, no longer insured under the Plan. Premium was paid for

the period June 1, 2000 through December 31, 2000, during which time the Plan insured Sheri Garay and at least one other non-owner, employee. A Summary of Current Period Premiums, which is included with the statement for January 1, 2001, indicates that there are five employees with coverage.

33. Attached as "**Exhibit BB**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of February 1, 2001 and March 1, 2001, a Group Enrollment Form, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective January 1, 2001 and thus, no longer insured under the Plan.

34. Attached as "**Exhibit CC**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of April 1, 2001, a Group Enrollment Form, and a premium check. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective March 1, 2001 and thus, no longer insured under the Plan. These documents further demonstrate that an employee of Site For Sore Eyes was added as an insured under the Plan effective March 1, 2001.

35. Attached as "**Exhibit DD**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of May 1, 2001, and a premium check. The statement demonstrates that an employee of Site For Sore Eyes was terminated effective March 22, 2001 and thus, no longer insured under the Plan.

36. Attached as "**Exhibit EE**" are true and correct copies of the *Group Insurance Premium Statement*s with due date of June 1, 2001 and July 1 2001, and premium checks. These documents demonstrate that a new employee of Site For Sore Eyes was added an insured under the Plan effective May 1, 2001.

37. Attached as "**Exhibit FF**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of August 1, 2001, and a premium check. This two page document demonstrates and an employee of Site For Sore Eyes was terminated effective July 1, 2001 and thus, no longer insured under the Plan.

38. Attached as "**Exhibit GG**" are true and correct copies of the *Group Insurance Premium Statements* with due dates of October 1, 2001 through December 1, 2001, three Group

Enrollment Forms, three premium checks, and an INS Employment Eligibility Verification Form. These documents demonstrate that two employees of Site For Sore Eyes were terminated effective October 1, 2001 and thus, no longer insured under the Plan. These documents further demonstrate that three new employees of Site For Sore Eyes were added as insured under the Plan effective September 1, 2001 and October 4, 2001. Premium was paid for the period January 1, 2001 through December 31, 2001, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

39. Attached as "**Exhibit HH**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of January 1, 2002 and February 1, 2002, and premium checks. These documents demonstrated that two employees of Site For Sore Eyes were terminated and thus, no longer insured under the Plan.

40. Attached as "**Exhibit II**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of March 1, 2002, and a premium check. This statement demonstrates that two new employees of Site For Sore Eyes were added as insureds under the Plan effective March 6, 2002 and February 1, 2002.

41. Attached as "**Exhibit JJ**" are true and correct copies of the *Group Insurance Premium Statement*s with due dates of April 1, 2002 through June 1, 2002, and three premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective April 1, 2002 and thus, no longer insured under the Plan.

42. Attached as "**Exhibit KK**" are true and correct copies of the *Group Insurance Premium Statements* with due dates of July 1, 2002 and August 1, 2002, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective July 1, 2002 and thus, no longer insured under the Plan. Premium was paid for the period January 1, 2002 through April 30, 2003, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

43. Attached as "**Exhibit LL**" is a true and correct copy of a *Group Insurance Premium Statement* with a due date of March 1, 2003, which names six employees, including Ms. Garay.

44. Attached as "**Exhibit MM**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of May 1, 2003, and premium check. This document demonstrates that an employee of Site For Sore Eyes was terminated effective May 1, 2003 and thus, no longer insured under the Plan.

45. Attached as "**Exhibit NN**" are true and correct copies of the *Group Insurance Premium Statements* with due date of June 1, 2003 and July 1, 2003, two Group Enrollment Forms, and premium checks. These documents demonstrate that an employee of Site For Sore Eyes was terminated effective June 1, 2003 and thus, no longer insured under the Plan. These documents further demonstrate that two new employees were added as insureds under the Plan effective June 1, 2003 and April 1, 2003.

46. Attached as "**Exhibit OO**" are true and correct copies of the *Group Insurance Premium Statement* with a due date of August 1, 2003, and premium check. This document demonstrates that an employee of Site For Sore Eyes was terminated effective May 1, 2003 and thus, no longer insured under the Plan.

47. Attached as "**Exhibit PP**" are true and correct copies of the *Group Insurance Premium Statements* with a due date of September 1, 2003 through January 1, 2004, and premium checks. These documents demonstrate that a new employee of Site For Sore Eyes was added as an insured under the Plan. Premium was paid for the period May 1, 2003 through December 31, 2003, during which time the Plan insured Sheri Garay and at least one other non-owner, employee.

48. I have been informed and believe that attached as "**Exhibit QQ**" is a true and correct copy of a Disability Claim form completed by plaintiff and received by UNUM on OR about June 19, 2002.

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49. I have been informed and believe that attached as "**Exhibit RR**" is a true and correct copy of Asset Purchase Agreement dated January 9, 2004 which was received by UNUM on or about February 18, 2004.

I declare under penalty of perjury of the laws of the United States of America that the foregoing is true and correct. Executed this 16th day of June, 2008 at Portland, Maine.

Anna M. Stein

EXHIBIT A

TABLE OF CONTENTS

UACL00071

LC-IND-1

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as "we," "our" and "us") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for insurance and you become and remain insured. Keep it in a safe place.

A few words about this certificate of coverage.....

We have written it in plain English. But a few terms and provisions are written as required by insurance law. You will want to read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

President

UACL00072

SUMMARY OF BENEFITS

Description of Eligible Classes

Refer to certificate rider LC-CR-RIDER.

Amount of Insurance

Refer to certificate rider LC-CR-RIDER.

Definition of 'Disability' or 'Disabled'

Refer to certificate rider LC-CR-RIDER.

Minimum Requirement for Active Employment: 30 hours per week

Changes Effective

Subject to the delayed effective date exceptions, changes in insurance take effect immediately.

UAC100073

TERMS YOU SHOULD KNOW

Many terms used in your certificate of coverage have special meanings. A list of these terms and meanings follows:

- "Active employment" means you must be working:
  1. for your employer on a full-time basis and paid regular earnings (temporary or seasonal employees are excluded);
  2. at least the minimum number of hours shown in the summary of benefits; and either
  3. at your employer's usual place of business; or
  4. at a location to which your employer's business requires you to travel.

- "Basic monthly earnings" - if you are:

  1. a Partner, means your average monthly earnings as figured:

     a. from the line which shows "net earnings (loss) from self-employment" from schedule K-1 of the partnership federal income tax return for the tax year just prior to the date disability begins; or

     b. for the period that you have been a partner if you were not a partner during the year for which the most recent partnership federal income tax return was filed.

  2. a Sole Proprietor, means your annual net profit averaged over:

     a. the 3 most recent years; or

     b. the period that you have been a sole proprietor, if you have been a sole proprietor for less than 3 years,

     then divided by 12.

     Annual net profit is figured on form 1040 Schedule C as the gross income less total deductions minus depreciation.

  3. an employee other than Partners or Sole Proprietors, means your average monthly earnings as figured:

     a. from the W-2 form (from the box which reflects wages, tips and other compensation) received from the employer for the calendar year just prior to the date disability begins; or

     b. for the period of employment if no W-2 form was received.

- "Disability benefits," when used with the term retirement plan, means money which:

  1. is payable under a retirement plan due to disability as defined in that plan; and

  2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as explained in this certificate of coverage.)

UACL00074

- "Eligibility date" means the date you become eligible for insurance after completing the waiting period shown in the certificate rider.

- "Elimination period" means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the certificate rider and begins on the first day of disability.

  Note: If disability stops during the elimination period for up to any 7 days for a 90 day elimination period or for any 14 days for a 180 day elimination period, then the disability will be treated as continuous. But days that you are not disabled will not count toward the elimination period.

- "Employer" means a proprietorship, partnership or corporation which becomes a participating employer by completing an application for participation and having the application approved by the Company and the trustees of the fund.

- "Gross monthly benefit" means your benefit amount before any reduction for other income benefits and earnings.

- "Home office" means the Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

- "Indexed pre-disability earnings" means your basic monthly earnings in effect just prior to the date your disability began adjusted on the first anniversary of benefit payments and each following anniversary. Each adjustment will be based on the lesser of 10% or the current annual percentage increase in the Consumer Price Index.

  Note: The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

- "Injury" means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur and disability must begin while you are insured under the policy.

- "Monthly benefit" means the amount we will pay you when you are disabled.

- "Physician" means a person who is:

  1. operating within the scope of his license; and either

  2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

  3. legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

  It will not include you or your spouse, daughter, son, father, mother, sister or brother.

UACL00075

- "Retirement benefits", when used with the term retirement plan, means money which:

  1. is payable under a retirement plan either in a lump sum or in the form of periodic payments;

  2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and

  3. is payable upon:
     a. early or normal retirement; or
     b. disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

- "Retirement plan" means a plan which provides your retirement benefits and which is not funded wholly by your contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

- "Sickness" means illness or disease. It includes pregnancy unless excluded in the General Exclusion section of this certificate of coverage. Disability must begin while you are insured under the policy.

- "Waiting period," as shown in the certificate rider, means the continuous length of time you must serve in an eligible class to reach your eligibility date.

- "You" and "your" means you, the employee.

UACL00076

ENROLLMENT AND DATE INSURANCE STARTS

When can you enroll?
You can enroll if you are:

1. in active employment with your employer; and
2. in a class eligible for insurance.

When does insurance start?
Insurance will start at 12:01 a.m. on the day determined as follows, but only if you enroll for insurance with us through your employer on a form satisfactory to us.

1. If you do not contribute toward the plan's cost, your insurance will start on your eligibility date.
2. If you do contribute toward the plan's cost, your insurance will start on the latest of these dates:
   a. your eligibility date. But you must enroll on or before this date.
   b. the date you enroll if you do so within 31 days after your eligibility date.
   c. the date we give approval, if you:
      i. apply more than 31 days after your eligibility date; or
      ii. terminated your insurance while still eligible.

   In the case of i. and ii. above, you must submit, at your expense, an application and evidence of insurability to us for approval.

   "Evidence of insurability" means a statement or proof of your medical history upon which we will determine your acceptance for insurance.

But no initial, increased or additional insurance will apply to you if you are not in active employment on the effective date of such insurance because of a disability. Such insurance will start for you on the day you return to active employment.

UACL00077

DISABILITY

When do disability benefits become payable?
We will pay you a monthly benefit after the end of the elimination period when we receive proof that you:

1. are disabled due to sickness or injury; and

2. require the regular attendance of a physician.

What conditions must be met for benefit payments to continue?
We will pay you as long as you remain disabled and require the regular attendance of a physician. But we will not pay any longer than the maximum benefit period shown below:

Age at Disability	Maximum Benefit Period
Less than age 60	To age 65 but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Also, you must give us proof of these facts, at your own expense, when we ask for it.

When do disability benefits for partial disability become payable?
When we receive proof that you are partially disabled within 31 days of the end of a period during which you received disability benefits, we will pay a monthly benefit. The partial disability must result from the injury or sickness that caused disability.

How is the benefit figured?

To figure the amount of your monthly benefit:

Refer to certificate rider LC-CR-RIDER.

UAC100078

But, if you are earning more than 20% of your indexed pre-disability earnings in your regular occupation or another occupation, then the monthly benefit will be figured as follows:

1. During the first 12 months, the monthly benefit will not be reduced by any earnings until the gross monthly benefit plus your earnings exceed 100% of your indexed pre-disability earnings. The monthly benefit will then be reduced by that excess amount.

2. After 12 months, the following formula will be used to figure the monthly benefit.

(A divided by B) x C

A = Your "indexed pre-disability earnings" minus your monthly earnings received while you are disabled.

B = Your "indexed pre-disability earnings".

C = The benefit as figured above.

The benefit payable will never be less than the minimum monthly benefit shown in the certificate rider.

Proof of your monthly earnings must be given to us on a quarterly basis. Benefit payments will be adjusted upon receipt of this proof of earnings.

What are "other income benefits"?
Other income benefits means those benefits as follows.

1. The amount for which you are eligible under:

   a. Workers' or Workmen's Compensation Law;
   b. occupational disease law; or
   c. any other act or law of like intent.

2. The amount of any disability income benefits for which you are eligible under any compulsory benefit act or law.

3. The amount of any disability income benefits for which you are eligible under:

   a. any other group insurance plan;
   b. any governmental retirement system as a result of your job with your employer.

4. The amount of benefits from your employer's retirement plan you:

   a. receive as disability benefits;
   b. voluntarily elect to receive as retirement benefits; or
   c. receive as retirement benefits when you reach the greater of age 62 or normal retirement age, as defined in your employer's retirement plan.

   As used here, "received" does not include any amount rolled over or transferred to any eligible retirement plan as that term is defined in Section 402 of the Internal Revenue Code and any future amendments which affect the definition of an eligible retirement plan.

UACL00079

5. The amount of disability or retirement benefits under the United States Social Security Act, The Canada Pension Plan, or the Quebec Pension Plan, or any similar plan or act, as follows:

   a. disability benefits for which:

      i. you are eligible; and
      ii. your spouse, child or children are eligible because of your disability; or

   b. retirement benefits received by:

      i. you; and
      ii. your spouse, child or children because of your receipt of the retirement benefits.

These other income benefits, except retirement benefits, must be payable as a result of the same disability for which we pay a benefit.

Item 5.b will not apply to disabilities which begin after age 70 if you are already receiving Social Security retirement benefits while continuing to work beyond age 70.

Benefits under item 5.a above will be estimated if such benefits:

1. have not been awarded; and
2. have not been denied; or
3. have been denied and the denial is being appealed.

The monthly benefit will be reduced by the estimated amount. But, these benefits will not be estimated provided that you:

1. apply for benefits under item 5.a; and
2. request and sign our Agreement Concerning Benefits.

This agreement states that you promise to repay us any overpayment caused by an award received under item 5.a. If benefits have been estimated, the monthly benefit will be adjusted when we receive proof:

1. of the amount awarded; or
2. that benefits have been denied and the denial is not being appealed.

In the case of 2. directly above, a lump sum refund of the estimated amounts will be made.

"Law", "plan", or "act" means the initial enactment and all amendments.

For Connecticut and Maryland employers only:
What happens if you receive increases in these other income benefits?
After the first deduction for each of the other income benefits, we will not further reduce your monthly benefit due to any increases payable under these other income benefits.

For All Other Employers:
What happens if you receive increases in these other income benefits?
After the first deduction for each of the other income benefits, we will not further reduce your monthly benefit due to any cost of living increases payable under these other income benefits.

What if you receive a lump sum payment?
We will prorate other income benefits which are paid in a lump sum on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over your expected lifetime as determined by us.

UACL00080

When do these benefits cease?
Disability benefits will cease on the earliest of:

1. the date you are no longer disabled;
2. the date you die;
3. the end of the maximum benefit period;
4. the date your current earnings exceed 80% of your indexed pre-disability earnings.

Must premium payments be made when you are receiving benefits?
No, we will waive premium payments during any period for which benefits are payable.

RECURRENT DISABILITY

What happens if you try to return to work and become disabled again?
"Recurrent Disability" is a disability which is related to a prior disability for which you received a monthly benefit.

We will treat a recurrent disability as part of the prior disability if, after receiving disability benefits, you:

1. return to your regular occupation on a full-time basis for less than six months; and
2. perform all the material duties of your occupation.

Benefit payments will be subject to the terms of this plan for the prior disability.

If you return to your regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability. You must complete another elimination period.

In order to prevent overinsurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to you under any other group long term disability policy.

SURVIVOR BENEFIT

What happens to your benefit if you die?
We will pay a benefit to your eligible survivor when we receive proof that you died:

1. after disability had continued for 180 or more consecutive days; and
2. while receiving a monthly benefit.

The benefit will be an amount equal to three times your gross monthly benefit.

If payment becomes due to your children, payment will be made to:

1. your children; or
2. a person named by us to receive payments on your children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent your children.

"Eligible survivor" means your spouse, if living, otherwise your children under age 25. But, if there are no eligible survivors, payment will be made to your estate.

GENERAL EXCLUSIONS

What disabilities aren't covered?
We will not cover any disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot.

PRE-EXISTING CONDITION EXCLUSION

If your certificate rider shows a Pre-existing Condition provision, then the following Pre-existing Condition Exclusion provision does not apply to you. The Pre-existing Condition provision shown in your certificate rider applies to you.

Are there any other disabilities not covered?
Yes, we will not cover any disability that is caused by, contributed to by, or results from a pre-existing condition. But that disability will be covered if it begins after a period of 12 consecutive months starting on or after your effective date of coverage, during which you have not:

1. received medical treatment, consultation, care or services including diagnostic measures; or
2. taken prescribed drugs or medicines.

"Pre-existing condition" means a sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the 24 months prior to your effective date.

MENTAL ILLNESS LIMITATION

Are benefits limited for mental illness?
Benefits for disability due to mental illness will not exceed 24 months of monthly benefit payments unless you meet one of these situations.

1. You are in a hospital or institution at the end of the 24-month period. We will pay the monthly benefit during the confinement.

   If you are still disabled when discharged, we will pay the monthly benefit for a recovery period of up to 90 days.

   If you become reconfined during the recovery period for at least 14 days in a row, we will pay benefits for the confinement and another recovery period up to 90 more days.

2. You continue to be disabled and become confined:

   a. after the 24-month period; and

   b. for at least 14 days in a row.

   We will pay the monthly benefit during the confinement.

We will not pay the monthly benefit beyond the maximum benefit period.

"Hospital" or "institution" means facilities licensed to provide care and treatment for the condition causing your disability.

"Mental illness" means mental, nervous or emotional diseases or disorders of any type.

UACL00082

CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

Are you covered if you are not in active employment due to injury or sickness?
We will cover you, subject to premium payments, if you:

1. were insured with the prior carrier at the time of transfer; and
2. are not in active employment due to injury or sickness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Will a disability due to a pre-existing condition be covered?
Benefits may be payable for a disability due to a pre-existing condition if you:

1. were insured by the prior carrier at the time of transfer; and
2. were in active employment and insured under this plan on its effective date.

We will pay you the benefits under this plan if you satisfy the pre-existing condition provision under:

1. this plan; or
2. the prior carrier's policy, considering continuous time insured under both policies.

The benefit will be determined according to this plan's benefit schedule but it will not exceed the prior carrier's maximum monthly benefit. No benefit will be paid if you cannot satisfy the pre-existing condition provision of 1. or 2. directly above.

UACL00083

TERMINATION

When does your insurance terminate?
You will cease to be insured on the earliest of the following dates:

1. the date the policy terminates;
2. the date your employer's coverage under the policy terminates;
3. the date you are no longer in an eligible class;
4. the date your class is no longer included for insurance;
5. the last day for which you made any required employee contribution;
6. the date employment terminates. Cessation of active employment will be deemed termination of employment, except:
   a. if you are disabled your insurance will be continued during:
      i. the elimination period; and
      ii. while benefits are being paid.
   b. your employer may continue your insurance by paying the required premium, subject to the following:
      i. Insurance may be continued to the end of the insurance month following the insurance month in which you are:
         a) temporarily laid off; or
         b) given leave of absence.
      ii. The employer must act so as not to discriminate unfairly among employees in similar situations.

CONVERSION PRIVILEGE

Under what conditions can you convert?
When your coverage under this plan terminates because you end employment with your employer, you may obtain converted disability income coverage without medical evidence of insurability. But you must have been insured for at least twelve consecutive months just before your insurance under this plan terminated. These twelve months will be considered to include the time you were insured for group long term disability under both this plan and the one it replaced, if any.

Who may not convert?
The conversion privilege is not available to you if:

1. your insurance under this plan terminates for any of the following reasons:
   a. this plan terminates;
   b. your employer's coverage under this plan terminates;
   c. this plan is amended to exclude from coverage the class of employees to which you belong;
   d. you no longer belong to a class of employees eligible for coverage under this plan;
   e. you retire (when you receive payment from any employer's retirement plan as recognition of past services or have concluded your working career);
   f. you failed to pay any required premium;

UACL00084

2. you are or become insured for long term disability insurance under another group plan within 31 days after termination; or

3. you are disabled under the terms of this plan.

4. you recover from a disability and do not return to work for your employer; or

5. you are on a leave of absence.

When must you apply for the conversion coverage?
You must apply for and pay the first quarterly premium for the conversion coverage within 31 days after your insurance terminates under this plan.

Is the conversion coverage the same as that provided under this plan?
The Company governs the form of coverage, the benefits and the amounts. The benefits and amounts may differ from those under this plan.

UACL00085

SOME GENERAL INFORMATION TO KNOW

When must we be notified of a claim?
You must give us written notice of claim within 30 days of the date disability starts. If that is not possible, you must notify us as soon as you can.

When we receive your written notice of claim, we will send you our claim forms. If you do not receive the forms within 15 days after you sent the notice, you can send written proof of claim without waiting for the form.

When does proof of claim have to be given?
You must give us proof of claim no later than 90 days after the end of the elimination period.

If it is not possible for you to give proof within these time limits, it must be given as soon as reasonably possible. But you may not give proof later than one year after the time it is otherwise required.

You must give us proof of continued disability and regular attendance of a physician within 30 days of the date we request the proof.

The proof must cover:

1. the date disability started;
2. the cause of disability; and
3. how serious the disability is.

When are claims paid?
When we receive proof of claim, benefits payable under the policy will be paid monthly during any period for which we are liable.

Who are claims paid to?
All benefits are payable to you. But if a benefit is payable to your estate, or if you are a minor, or you are not competent, we have the right to pay up to $1,000 to any of your relatives whom we consider entitled. If we pay benefits in good faith to a relative, we will not have to pay such benefits again.

What are our examination rights?
We, at our expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of claim:

1. examined by a physician, other health professional, or vocational expert of our choice; and/or
2. interviewed by an authorized Company representative. This right may be used as often as reasonably required.

How can statements made in any application for this insurance be used?
In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim unless a copy of your statements has been given to you.

Can legal proceedings be started at any time?
No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

UACL00086

What happens if facts are misstated?
If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid.

Does this coverage affect workers' or workmen's compensation?
The policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

Can the policyholder act as our agent?
For all purposes of the policy, the policyholder acts on its own or as your agent. Under no circumstances will the policyholder be deemed our agent.

UACL00087

UNUM.

This rider is attached to and made a part of the certificate which was issued to you under the coverage provided for:

Site for Sore Eyes

Group Identification No. 108121

- DESCRIPTION OF ELIGIBLE CLASSES

  All employees of each participating employer.

- AMOUNT OF INSURANCE

  1. 60% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit, less other income benefits.

     Note: This benefit is subject to reductions for earnings as provided in the section titled "How is the benefit figured?"

  2. The maximum monthly benefit is $6000.
  3. The minimum monthly benefit is the greater of:
     a. $100.00; or
     b. 10% of the monthly benefit before deductions for other income benefits.

- ELIMINATION PERIOD

  180 Days

- WAITING PERIOD

  If you were in an eligible class on or before the policy effective date: NONE

  If you entered an eligible class after the policy effective date: 30 Days

  You must be in continuous active employment in an eligible class during the specified waiting period.

  Previous service in an eligible or an ineligible class will apply toward the waiting period to determine your date of eligibility.

UACL01201

LC-CR-RIDER

- CONTRIBUTIONS

  For Partners or Sole Proprietors

  - The cost of your insurance is paid by you.

  For All Others

  - The cost of your insurance is paid entirely by your employer.

- DEFINITION OF DISABILITY

  "Disability" and "disabled" mean that because of injury or sickness:

  1. you cannot perform each of the material duties of your regular occupation; and
  2. after benefits have been paid for 24 months, you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience; or
  3. you, while unable to perform all of the material duties of your regular occupation on a full-time basis, are:
     a. Performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and
     b. Currently earning at least 20% less per month than your indexed pre-disability earnings due to that same injury or sickness.

  Note: Reference to a partial disability, in the accompanying booklet which describes your benefits, does not apply to you when you have this definition of disability.

  Definition of Disability for employees employed as airplane pilots, co-pilots or crew members.

  "Disability" and "disabled" mean that because of injury or sickness you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute disability.

UACL01202

- HOW IS THE BENEFIT FIGURED?

  To figure the amount of your monthly benefit:

  a. Take the lesser of:

     i. 60% of your basic monthly earnings; or

     ii. the amount of the maximum monthly benefit; and

  b. Deduct other income benefits from this amount.

The effective date of this rider is **October 1, 1995**, or the effective date of your certificate, whichever is later.

These provisions only apply to disabilities which start on or after the effective date.

Dated at Portland, Maine this **23rd** day of **October, 1995**.

UNUM Life Insurance Company of America

UACL01203

LC-CR-RIDER

FOR HOME OFFICE USE ONLY

Please write in the BOOKLET used in conjunction with this rider and attach this sheet to the HOME OFFICE copy of this rider only. THANK YOU!!

Booklet Used: MP Standard

OTHER COMMENTS:

UACL01204

The changes shown below are made a part of the certificate which was issued to:

Site for Sore Eyes

Group Identification No. **108121**

1. If the employer fails to pay any premium within the grace period, the employer's coverage under the policy will automatically terminate at 12:00 midnight of the last day of the grace period. The employer may terminate coverage under the policy by advance written notice delivered to the Insurance Company at least 31 days prior to the termination day. But this coverage will not terminate during any period for which premium has been paid. The employer will be liable to the Insurance Company for all premiums due and unpaid for the full period the employer's coverage is in force.
2. The Insurance Company may terminate the employer's coverage under the policy on any premium due date by giving written notice to the employer at least 31 days in advance if:
   a. the number of employees insured is less than 2; or
   b. for employers with under 10 lives, less than 100% of the employees eligible for insurance are insured for it; or
   c. for employers with 10 or more lives, less than 75% of the employees eligible for any contributory insurance are insured for it; or
   d. for employers with 10 or more lives, less than 100% of the employees eligible for any non-contributory insurance are insured for it; or
   e. the employer fails:
      i. to furnish promptly any information which the Insurance Company may require; or
      ii. to perform any other obligations pertaining to this plan of insurance.
3. Termination may take effect on an earlier date when both the employer and the Insurance Company agree.

The effective date of this rider is **October 1, 1995**.

Dated at Portland, Maine this 23rd day of **October, 1995**.

UNUM Life Insurance Company of America

UNUM.

UACL01205

CR-TERM-1

Claimant Name: Sheri Garay Claim #: 322239

UNUM.

APPLICATION FOR PARTICIPATION IN THE SELECT GROUP INSURANCE TRUST

To: The Trustee(s) of The Select Group Insurance Trust and UNUM Life Insurance Company of America

Name of Employer/Applicant SHERI A. GARAY DBA SITE FOR SORE EYES

Address: 1003 WILLOW PASS RD

CONCORD (City) CA (State) 94520 (Zip)

requests approval to participate in the above named Insurance and for its eligible employees under the terms of the group policy(ies) issued to the Trustee(s) of the Trust for the following coverage(s):

- ☐ Group Life Benefits
- ☐ Group Accidental Death and Dismemberment Benefits
- ☐ Group Short Term Disability Benefits
- ☒ Group Long Term Disability Benefits

By this application, the Employer/Applicant:

1. agrees and accepts the terms of the Trust Agreement (including all amendments to the Trust Agreement) for the Insurance Trust named above for so long as it elects to participate in the Trust;
2. agrees to remit regularly the required premium payments; and
3. elects coverage as shown in the Summary of Benefits and agrees that only those provisions which appear in the Summary of Benefits provided to the Employer/Applicant apply to its insurance coverage.

The effective date of coverage is to be _____ or the date the Insurance Company approves, whichever is later. No insurance for which evidence of insurability is required will become effective until approved by the Insurance Company at its home office.

Dated at CONCORD CA By (Employer/Applicant) [signature]

on 10-2-95 By [signature] (Agent or Broker Signature)

UACL01206

1525-80 (7-94) Mini-File

EXHIBIT B

LONG TERM DISABILITY MINI-PLAN PROPOSAL Ver. 2.5

Prepared for: SHERI A. GRAY DBA SITE FOR SORE EYES
Prepared by : LEON I. BILLANT, CLU

Industry : 5912 - Drug & Proprietary Stores
Eligibility : This proposal for Long Term Disability coverage includes all active full-time employees working a minimum of 30 hours per week.

Definition of Disability : Two Year Own Occupation w/Residual
Integration Method : Primary & Family (Full Integration)
Number of eligible employees : 4
Monthly Benefit Amount : 60% of salary to a maximum benefit of $6,000 pe month. This insures a monthly salary of $10,000
Elimination Period : 180 Days
Total Monthly Covered Payroll: $15,499

	First Name	Last Name	Social Security #	Birth Date	Age	Occupation
1.	SHERRI	A		9/02/62	33	SALES
2.	WAYNE	C		1/24/64	31	LAB TECH
3.	SHERI	GARAY		7/17/52	43	OWNER-SALES
4.	STACY	S		2/15/72	23	SALES
5.						
6.						
7.						
8.						
9.						

	Last Name	Mth. Earn.	ID Cover	Covered Payroll	x	Rate	x	Adj. Fact.	=	Mth. Premium
1.	A	3,000		3,000		.0040		1.25		$15.00
2.	C	1,916		1,916		.0040		1.25		$9.58
3.	GARAY	8,333		8,333		.0072		1.25		$75.00
4.	S	2,250		2,250		.0040		1.25		$11.25
5.										
6.										
7.										
8.										
9.										

TOTAL MONTHLY LTD PREMIUM $110.83

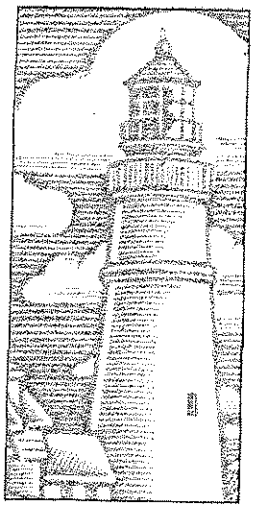
The above is based on census data received by UNUM. Actual costs will be based on the final enrollment data of employees insured under the plan on its effective date. Benefits and rates shown are effective until the case is issued or until UNUM gives notice of a rate change, whichever is earlier. Other product features, exclusions and limitations can be found in Proposal Highlights.

Effective Date: 10/01/95
Proposal Date: 10/06/95

UNUM Life Insurance Company of America

REDACTED

EXHIBIT C



MINI-PLAN℠
GROUP INSURANCE FOR
SMALL BUSINESSES

Mini-Plan℠ Benefits & Cost Summary

Prepared for:
Submitted by:

This proposal for Mini-Plan℠ coverage includes all active full-time employees working a minimum of 30 hours per week.

The Mini-Plan coverage being proposed:* ☒ LTD ☐ STD ☐ Life/AD&D

Number of Eligible Employees:

Waiting Period for new hires: ☒ 30 Days ☐ 60 Days ☐ 90 Days

LTD Benefits

Monthly Benefit Amount:** $3,000 - $6,000
60% of salary to a maximum benefit of $ 5,000 per month.

Definition of Disability: ☐ 2 Year Own Occupation with Partial
☒ 2 Year Own Occupation with Residual

Benefits reduced by amounts from:
☒ Primary and Family ☐ 70% All Sources

Elimination Period: ☐ 90 Days ☒ 180 Days

Total LTD Monthly Covered Payroll: $_____

STD Benefits

Benefit Duration: ☐ 13 Weeks ☐ 26 Weeks
(Elimination period: 0 days injury and 7 days sickness.)
(60% of salary to a maximum benefit of $500 per week.)

Life Benefits

Life Benefit Amount (and matching AD&D):
☐ $25,000
☐ 1 x salary ($50,000 max. benefit)
☐ 2 x salary ($50,000 max. benefit)

TOTAL MONTHLY COST: LTD $ 18.50 **STD $** _____ **Life/AD&D $** _____

Special features and pre-existing condition exclusions are outlined in the proposal highlights.

The above is based on census data received by UNUM. Actual costs will be based on the final enrollment data of employees insured under the plan on its effective date. Benefits and rates shown are effective until the case is issued or until UNUM gives notice of a rate change, whichever is earlier.

* Short Term Disability benefits are not available where statutory disability income benefits are mandated; and Evidence of Insurability is required in some states for certain Mini-Plan coverages. Please talk to your UNUM representative regarding individual state requirements.

** Maximum benefit is $3,000 in South Carolina.

PLEASE FILL OUT CLIENT INFORMATION ON THE BACK OF THIS PAGE.

UNUM®

523-94

Mini Plan℠ Premium Calculation Worksheet

Company Name: SHERRI GARAY DBA SICE FOR SORE EYES

Nature of Business: RETAIL EYEGLASS STORE SIC Code:

Instructions for Completion of this Worksheet:

1) Complete Census Information Section. Note: Employee age is age as of effective date.
2) For each coverage (LTD, STD, Life/AD&D) determine employee premium as described on the right hand side of this workshee
   All employees must have the same plan design.
3) Enter the total premium for each coverage in the space provided.

Census Information

Employee's Name	Social Security #	Date of Birth	Age	Occupation	Annual Earnings
A SHERRI	REDACTED	9-2-61	33	SALES	36,000
C WAYNE		1-24-64	31	LAB TECH	23,000
GARAY SHERRI		7-17-52	43	OWNER-SALES	100,000
S STACY		2-15-72	23	SALES	27,000

Rate Information

Long Term Disability Rates

Definition of Disability:	2 Year Own Occupation with Partial				2 Year Own Occupation with Residual			
Benefit Integration:	Family		70% All Sources		Family		70% All Sources	
Elimination Period:	90-Day	180-Day	90-Day	180-Day	90-Day	180-Day	90-Day	180-Day
Age	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan I*	☐ Plan J*	☐ Plan K*	☐ Plan L*
<30	$0.49	$0.39	$0.58	$0.45	$0.50	$0.40	$0.59	$0.46
30-34	0.49	0.39	0.58	0.45	0.50	0.40	0.59	0.46
35-39	0.68	0.47	0.79	0.55	0.69	0.48	0.81	0.56
40-44	1.02	0.71	1.21	0.84	1.04	0.72	1.23	0.86
45-49	1.65	1.26	1.95	1.49	1.68	1.29	1.99	1.52
50-54	2.52	2.02	2.99	2.40	2.57	2.06	3.05	2.45
55-59	3.12	2.58	3.70	3.06	3.18	2.63	3.77	3.12
60-64	3.27	2.71	3.88	3.22	3.34	2.76	3.96	3.28
65+	3.29	2.78	3.90	3.29	3.36	2.84	3.98	3.36

*Plans E-H are no longer available

Life/AD&D Rates/All Plans

Age	$25,000 ☐ Plan A	1 x earnings ☐ Plan B	2 x earnings ☐ Plan C
<30		$0.20	
30-34		0.21	
35-39		0.27	
40-44		0.39	
45-49		0.62	
50-54		1.06	
55-59		1.69	
60-64		1.95	
65-69		3.35	
70+		8.21	

Short Term Disability Rates

Age	13 Weeks ☐ Plan A	26 Weeks ☐ Plan B
<30	$0.80	$1.01
30-34	0.73	0.90
35-39	0.73	0.90
40-44	0.73	1.04
45-49	0.81	1.16
50-54	0.96	1.45
55-59	1.21	1.93
60-64	1.36	2.59
65-69	1.49	2.77
70+	2.21	4.11

ates are subject to change. Initial base rate tables are guaranteed for two years from effective date.

EXHIBIT D

UNUM LIFE

SELECT RISK QUESTIONNAIRE

UNUM.

Employer Name: SHORI A. GARAY DBA Site For Sore Eyes

Address: 1003 Willow Pass Rd. Concord CA 94520

Please answer the following two questions to the best of your knowledge with regard to all eligible employees and dependents.

1. Have any eligible employees or dependents been treated for a serious medical condition during the past 12 months? If yes, please provide details.

2. Are any eligible employees or dependents presently disabled? If yes, please provide details.

Applicant's Signature

Owner 10-2-95

Title Date

208 (7/94)

EXHIBIT E

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 12/01/95 Statement Date 12/06/95

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		110.84
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	115.88	
Balance from Prior Period (A-B)		115.88
TOTAL PREMIUM DUE		226.72

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,SHERRI	3000	15.00			
C ,WAYNE	1917	9.59			
GARAY,SHERI	6333	75.00			
S ,STACY	2250	11.25			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

EXHIBIT F

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 01/01/96 Statement Date 12/19/95

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		110.84
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	226.72	
Balance from Prior Period (A-B)		226.72
TOTAL PREMIUM DUE		337.56

For billing questions, please call
(800) 421-0344

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,SHERRI	3000	15.00			
C ,WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			
S ,STACY	2250	11.25			

110.84
JAN 10

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

UG-000035

REDACTED

EXHIBIT G

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 02/01/96 Statement Date 01/19/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF PREMIUMS DUE

Current Period Premium		110.84
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	337.56 337.56	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		110.84

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE										CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,SHERRI	3000										15.00			
C ,WAYNE	1917										9.59			
GARAY,SHERI	8333										75.00			
S ,STACY	2250										11.25			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

REDACTED

UG-000037

EXHIBIT H

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 03/01/96 Statement Date 02/18/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		119.59
Adjustments to Prior Period's Premium		26.25
Prior Period (A) Amount Billed (B) Amount Paid	110.84 110.84	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		145.84

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	15.00			
A ,CASSANDRA	1750	8.75			
C ,WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			
S ,STACY	2250	11.25			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K4-14409 04

PLEASE RETURN WITH PAYMENT

REDACTED

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0373331 Division No. 001 3
Due Date 04/01/96 Statement Date 03/19/96

ROSEN CONSULTING GROUP

SUMMARY OF PREMIUMS DUE

Current Period Premium		484.69
Adjustments to Prior Period's Premium		9.24
Prior Period (A) Amount Billed (B) Amount Paid	389.09 389.09	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		493.93

For billing questions, please call
(800) 421-0344

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	H-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,MATTHEW	4166	16.50			
H ,NANCY	5408	76.90			
L ,LORI	2333	9.24			
M [redacted]	7083	39.52			
P ,GREGORY	3333	13.20			
S ,JOHN	3000	11.88			
T ,MICHAEL	10000	55.80			
U ,SUSAN	5583	22.11			
V ,DANIEL	8333	183.74			
V ,ARIANNA	10000	55.80			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14408 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0374363 Division No. 001 1
Due Date 05/01/96 Statement Date 04/04/96

ORTHOPEDIC REHABILITATION
SPECIALISTS

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		39.24
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	 63.90 63.90	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		39.24

For billing questions, please call
(800) 421-0344

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	LIFE COVERAGE	XLIFE COVERAGE	AD&D COVERAGE	XAD&D COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
C ,SANDY MV	21000		21000		3.78			
H ,EDMOND H	21000		21000		3.78			
N ,CRAIG B	60000	20000	60000	20000	14.40			
N ,CURT K	45000		45000		8.10			
Y ,ANN A	28000		28000		5.04			
Y ,OLIVIA C	23000		23000		4.14			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

L7-14411 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 06/01/96 Statement Date 05/09/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		119.59
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	 119.59 119.59	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		119.59

For billing questions, please call
(800) 421-0344

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,SHERRI	3000	15.00			
A ,CASSANDRA M	1750	8.75			
C ,WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			
S ,STACY	2250	11.25			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

KA-84409 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 07/01/96 Statement Date 06/07/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF PREMIUMS DUE

Current Period Premium		119.59
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	 119.59 119.59	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		119.59

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA BOX 21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A ,SHERRI	3000	15.00			
A .CASSANDRA M	1750	8.75			
C ,WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			
S ,STACY	2250	11.25			

* Current premium due excluding adjustments - refer to adjustment page.

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

UG-000043

REDACTED

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0288981 Division No. 002 4
Due Date 08/01/96 Statement Date 07/19/96

RIEDE MCCALL & MASON

SUMMARY OF PREMIUMS DUE

Current Period Premium		561.26
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	561.26 561.26	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		561.26

For billing questions, please call
(800) 421-0344

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE										CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
M TERREL	10000										126.40			
M JOHN	10000										196.00			
M EILEEN C	1750										22.12			
R RICHARD	10000										196.00			
Y CAROLYN	2700										20.74			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14408 04

PLEASE RETURN WITH PAYMENT

REDACTED

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. D108121 Division No. 001 4
Due Date 09/01/96 Statement Date 08/08/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF PREMIUMS DUE

Current Period Premium		119.59
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	119.59 119.59	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		119.59

For billing questions, please call
(800) 421-0344

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21145
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	15.00			
A CASSANDRA M	1750	8.75			
C WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			
S STACY	2250	11.25			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

EXHIBIT I

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 10/01/96 Statement Date 09/18/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		128.01
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	119.59 119.59	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		128.01

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE										CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000										18.00			
A CASSANDRA M	1750										8.75			
C HAYNE	1917										9.59			
GARAY,SHERI	8333										75.00			
M AUA A	1083										5.42	T	9/24/96	
S STACY	2250										11.25	T	9/28/96	

pd

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

UNUM

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0107903 Division No. 001 7
Due Date 11/01/96 Statement Date 10/20/96

SUGARMAN & COMPANY

SUMMARY OF PREMIUMS DUE

Current Period Premium		519.86
Adjustments to Prior Period's Premium		-136.00
Prior Period (A) Amount Billed (B) Amount Paid	589.39 589.39	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		383.86

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	H-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
C DIANE	3063	31.86			
E KYLE	8333	57.50			
F DAVID	7500	78.00			
N STUART	5000	34.50			
S RANDY	10000	318.00			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14609 04

PLEASE RETURN WITH PAYMENT

EXHIBIT J

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 12/01/96 Statement Date 11/18/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT L421195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium	142.57
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed 125.90 (B) Amount Paid 125.90	
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	142.57

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	18.00			
A CASSANDRA M	1750	8.75			
C WAYNE	1917	4.54			
GARAY,SHERI	8333	75.00			
S RAMOES E	1215	11.23	T		

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card
C = Class change.
IF OTHER, PLEASE SPECIFY

X6-14[illegible] 04

PLEASE RETURN WITH PAYMENT

REDACTED

UG-000050

EXHIBIT K

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 01/01/97 Statement Date 12/19/96

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		111.34
Adjustments to Prior Period's Premium		-31.23
Prior Period (A) Amount Billed (B) Amount Paid	142.57 142.57	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		80.11

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE										CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000										18.00			
A CASSANDRA M	1750										8.75			
C HAYNE	1917										9.59			
GARAY,SHERI	8333										75.00			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

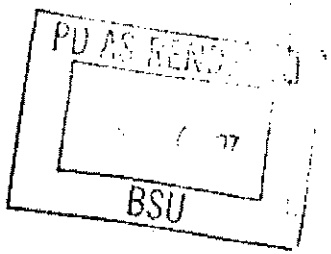
UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0100121 Division No. 001 4
Due Date 02/01/97 Statement Date 01/09/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195



SUMMARY OF PREMIUMS DUE

Current Period Premium		111.34
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	80.11 80.11	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		111.34

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	H-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	18.00			
A CASSANDRA H	1750	8.75			
C WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

96-14409 04

PLEASE RETURN WITH PAYMENT

EXHIBIT L

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 03/01/97 Statement Date 02/16/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		169.28
Adjustments to Prior Period's Premium		115.88
Prior Period (A) Amount Billed (B) Amount Paid	111.34 111.34	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		285.16

For billing questions, please call
(800) 421-0344

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	18.00			
A CASSANDRA M	1750	8.75			
B NORMA R	2250	57.94			
C WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14409 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 04/01/97 Statement Date 03/19/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		169.28
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	285.16 285.16	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		169.28

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	10.00			
A CASSANDRA M	1750	8.75			
B NORMA R	2250	57.94			
C HAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

* Current premium due excluding adjustments - refer to adjustment page

K6-14409 04

PLEASE RETURN WITH PAYMENT

REDACTED

UG-000056

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 05/01/97 Statement Date 04/15/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF PREMIUMS DUE

Current Period Premium		169.28
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	169.28 169.28	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		169.28

For billing questions, please call
(800) 421-0344

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	18.00			
A CASSANDRA M	1750	8.75			
A NORMA R	2250	57.94			
A WAYNE	1917	9.59			
GARAY,SHERI	8333	75.00			

* Current premium due excluding adjustments - refer to adjustment page.

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

G-14411 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 08/01/97 Statement Date 07/20/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		228.69
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	 169.28 169.28	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		228.69

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0549

EMPLOYEE DETAIL

EMPLOYEE NAME / SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	3000	18.00			
A CASSANDRA M	1750	8.75			
B NORMA R	2250	57.94			
C HAYNE	1917	9.59			
GARAY,SHERI	8333	134.41			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

96-14411 04

PLEASE RETURN WITH PAYMENT

REDACTED

UG-000058

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 09/01/97 Statement Date 08/19/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF PREMIUMS DUE

Current Period Premium		228.69
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	228.69 228.69	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		228.69

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LAZ1195
PASADENA CA 91185-1195

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.		M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
SHERRI		3000	18.00			
A	CASSANDRA M	1750	8.75			
B	NORMA R	2250	57.94			
C	WAYNE	1917	9.59			
GARAY,SHERI		6333	134.41			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

K6-14411 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 10/01/97 Statement Date 09/18/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		228.69
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	228.69 228.69	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		228.69

For billing questions, please call
(800) 421-0344

Please pay as billed. Adjustments for changes received will be reflected on your next bill.

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM#	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
SHERRI	3000	18.00			
CASSANDRA M	1750	8.75			
NORMA R	2250	57.94			
WAYNE	1917	9.59			
GARAY,SHERI	8333	134.41			

Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

94-19411 04

PLEASE RETURN WITH PAYMENT

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0392105 Division No. 001 9
Due Date 11/01/97 Statement Date 10/19/97

GARY B CALLAHAN INC DBA
CALLAHAN & DEACON

SUMMARY OF PREMIUMS DUE

Current Period Premium		335.12
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	391.99 391.99	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		335.12

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

Please pay as billed. Changes received prior to the statement date are reflected on this bill.

or billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.	H-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
GARY	10000	243.20			
EDWARD	5182	65.50			
.NINA	2800	13.89			
MARI B	1080	3.80			
CYNTHIA V	1740	8.73			

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.

* Current premium due excluding adjustments - refer to adjustment page

R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

REDACTED

UG-000061

UNUM.

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001
Due Date 12/01/97 Statement Date 11/18/97

SHERI A. GARAY DBA
SITE FOR SORE EYES

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SUMMARY OF PREMIUMS DUE

Current Period Premium		228.69
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	228.69	
(B) Amount Paid	228.69	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		228.69

Please pay as billed. Changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

EMPLOYEE DETAIL

EMPLOYEE NAME / SOCIAL SECURITY NO.	M-LTD COVERAGE	CURRENT PREMIUM*	SHOW EMPLOYEE ADJUSTMENTS HERE: ADJ CODE	ADJ DATE	NEW ANNUAL SALARY
A SHERRI	5000	18.00			
A CASSANDRA M	1750	8.75			
S NORMA R	2250	57.94			
C WAYNE	1917	9.59			
GARAY,SHERI	8333	134.41			

* Current premium due excluding adjustments - refer to adjustment page

ADJUSTMENT CODES: A = Addition - Include completed enrollment form or card.
S = Salary change - Report salary not benefit amount.
T = Termination - Include last day worked.
R = Reinstatement - Include completed enrollment form or card.
C = Class change.
IF OTHER, PLEASE SPECIFY.

X6 74411 04 N

PLEASE RETURN THIS PAGE WITH PAYMENT

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	228.69
Policy No. 0108721	Division No. 001 4
Due Date 01/01/1998	Statement Date 12/19/1997

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344.

SUMMARY OF PREMIUMS DUE

Current Period Premium		228.69
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	228.69	
(B) Amount Paid	228.69	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		228.69

Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (in Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

86-14411 04 N

Please remit this page with your payment.

EXHIBIT M

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM.

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

TOTAL PREMIUM DUE	170.75
Policy No. 0198121	Division No. 001 4
Due Date 02/01/1998	Statement Date 01/19/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

PD AS RENDERED
FEB - 9 1998
BSU

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344.

SUMMARY OF PREMIUMS DUE

Current Period Premium		170.75
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	228.69	
(B) Amount Paid	228.69	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		170.75

Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (in Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	S Stacy J		2/15/72	1/1/98	2/1/98		25,000
S	A Casey				2/1/98		26,000
A	M Jessica		6/15/71	1/6/98	2/1/98		21,000

REDACTED

X6-14435 04 N

Please remit this page with your payment

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

TOTAL PREMIUM DUE	200.34
Policy No. 0108121	Division No. 001 4
Due Date 03/01/1998	Statement Date 02/16/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	189.92
Adjustments to Prior Period's Premium	10.42
Prior Period	
(A) Amount Billed	170.75
(B) Amount Paid	170.75
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	200.34

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14435 04 N

Please remit this page with your payment.

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
DEPT LA21195
PASADENA CA 91185-1195

TOTAL PREMIUM DUE	196.19
Policy No. 0108121	Division No. 001 4
Due Date 04/01/1998	Statement Date 03/19/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		192.01
Adjustments to Prior Period's Premium		4.18
Prior Period		
(A) Amount Billed	280.34	
(B) Amount Paid	280.34	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		196.19

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14435 04 N

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EXHIBIT N

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	192.01
Policy No. 0108121	Division No. 001 4
Due Date 06/01/1998	Statement Date 05/19/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

1720

JUN - 4 1998

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	192.01
Adjustments to Prior Period's Premium	2@96
Prior Period (A) Amount Billed	192.01
(B) Amount Paid	192.01
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	192.01

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	C Wayne		1/24/64	1/2/97	6/1/98		
T	S Stacy		2/25/72	12/29/97	6/1/98		

REDACTED

66-14428 04 M

Please remit this page with your payment.

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	192.01
Policy No. 0108121	Division No. 001 4
Due Date 07/01/1998	Statement Date 06/18/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Our fax number is (207) 770-8730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received *prior to the statement* date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		172.00
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	192.01	
(B) Amount Paid	172.00	
Balance from Prior Period (A-B)		20.01
TOTAL PREMIUM DUE		192.01

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14428 04 N

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	172.00
Policy No. 0168121	Division No. 001 4
Due Date 08/01/1998	Statement Date 07/17/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		172.00
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	192.01	
(B) Amount Paid	192.01	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		172.00

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14420 04 N

Please remit this page with your payment.

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM.

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	194.10
Policy No. 0108121	Division No. 001 4
Due Date 09/01/1998	Statement Date 08/10/1998

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Paid 9/8/98

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		183.00
Adjustments to Prior Period's Premium		11.00
Prior Period		
(A) Amount Billed	172.00	
(B) Amount Paid	172.00	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		194.10

- Addition - All Fields
- Salary Change - Name, Effective Date, Salary and SSN
- Termination - Name, Last Day Worked (Effective Date) and SSN
- Reinstatement - All Fields
- Class Change - Name, Effective Date and Class
- Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K4-14420 04 N

Please remit this page with your payment.

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	183.05
Policy No. 0108121	Division No. 001 4
Due Date 10/01/1998	Statement Date 09/18/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	183.05
Adjustments to Prior Period's Premium	
Prior Period	
(A) Amount Billed	194.10
(B) Amount Paid	194.10
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	183.05

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14420 04 N

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EXHIBIT O

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	183.05
Policy No. 0108121	Division No. 001 4
Due Date 11/01/1998	Statement Date 10/19/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		183.05
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	183.05	
(B) Amount Paid	183.05	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		183.05

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	A Casandra		7/07/69	1/24/96	10/26/98		

K6-14420 04 N

Please remit this page with your payment.

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(510) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12231

11/1/98

PAY TO THE ORDER OF Unum $ **183.05

One Hundred Eighty-Three and 05/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

50

MEMO 0108121

MP

REDACTED

EXHIBIT P

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	161.37
Policy No. 0108121	Division No. 001 4
Due Date 12/01/1998	Statement Date 11/17/1998

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	172.21
Adjustments to Prior Period's Premium	-10.84
Prior Period (A) Amount Billed 183.05 (B) Amount Paid 183.05	
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	161.37

- Addition - All Fields
- Salary Change - Name, Effective Date, Salary and SSN
- Termination - Name, Last Day Worked (Effective Date) and SSN
- Reinstatement - All Fields
- Class Change - Name, Effective Date and Class
- Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	M Jessica		6/15/71	1/6/98	11/18/98		

K6-14420 04 N

Please remit this page with your payment.

REDACTED

UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108121	001 4	Sheri A. Garay dba Sit for See Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
M	Jennifer	M.	

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked
05/04/1975	12/02/1998	☒ F ☐ M	$ 7.00 pr hr	☐ Weekly ☐ Monthly ☐ Annually	Weekly 40

11. Occupation/Title: Receptionist

12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.

Life/AD&D	☐ Yes ☐ No	LTD	☐ Yes ☐ No
STD	☐ Yes ☐ No	Dependent Life	☐ Yes ☐ No

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship
M	Ida	M.	Mother

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Jennifer Date: 12/02/1998

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) **UNUM COPY**

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(510) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12319

12/1/98

PAY TO THE ORDER OF Unum $ **161.37

One Hundred Sixty-One and 37/100********** DOLLARS

Security features included Details on back

Unum
Dept LA21195
Pasadena,Ca 91185

13

MEMO 0108121

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(510) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12416

12/26/98

PAY TO THE ORDER OF Unum $ **173.17

One Hundred Seventy-Three and 17/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT Q

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	173.17
Policy No. 0108121	Division No. 001 4
Due Date 01/01/1999	Statement Date 12/18/1998

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE	
Current Period Premium	181.92
Adjustments to Prior Period's Premium	-8.75
Prior Period (A) Amount Billed	161.37
(B) Amount Paid	161.37
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	173.17

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	E Kimberly		11/31/80		11/30/98		
T	S Kay		4/8/61		12/13/98		
A	M Jennifer		05/4/75	12/2/98			7.00 per hr

K6-14411 04 N

Please remit this page with your payment.

REDACTED

EXHIBIT R

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	157.14
Policy No. 0108121	Division No. 001 4
Due Date 02/01/1999	Statement Date 01/19/1999

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		169.53
Adjustments to Prior Period's Premium		-12.39
Prior Period		
(A) Amount Billed	173.17	
(B) Amount Paid	173.17	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		157.14

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	B Christine		3/9/47	1/16/99			460.00 per wee
A	L Richard		12/7/49	1/19/99			560.00 per wk

K6-14411 04 N

Please remit this page with your payment.

REDACTED

UNUM
Provident Life and Accident Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
10821		Site for Sore Eyes

4. Employee's Last Name: L — First: RICHARD — Middle Initial: J — 5. Social Security Number:

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked
12,7,49	1,16,99	☐ F ☒ M	$ 560.00	☒ Weekly ☐ Monthly ☐ Annually	Weekly 40 -

11. Occupation/Title: optician

12. Your employer will inform you of available coverages. Check no if you decline or coverage is not available.
Life/AD&D ☐ Yes ☐ No — LTD ☐ Yes ☐ No
STD ☐ Yes ☐ No — Dependent Life ☐ Yes ☐ No

13. Beneficiary(ies) Last Name: L — First: Yvette — Middle Initial: S — 14. Relationship: wife

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of [illegible] y expense.

Employee's Signature: [signature] Date: 1,19,99

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	___/___/_____	____ STD	___/___/_____
____ Dep Life	___/___/_____	____ LTD	___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98)

UNUM COPY

REDACTED

UNUM

Unum Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
108121		Site for Sore Eyes

4. Employee's Last Name: B — First: CHRISTINE — Middle Initial: A — 5. Social Security Number:

6. Birthdate: 03/09/47

7. Employment Date: 01/12/99

8. Sex: ☒ F ☐ M

9. Salary: $ 460.00 ☒ Weekly ☐ Monthly ☐ Annually

10. Hours Worked Weekly: 40

11. Occupation/Title: Optician

12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☐ No — LTD ☐ Yes ☐ No

STD ☐ Yes ☐ No — Dependent Life ☐ Yes ☐ No

13. Beneficiary(ies) Last Name: B — First: CHARLES — Middle Initial: G. — 14. Relationship: Husband

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: [signature] Date: 1/16/99

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98)

UNUM COPY

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12525

1/25/99

PAY TO THE ORDER OF Unum $ **157.14

One Hundred Fifty-Seven and 14/100********** DOLLARS

Security features included Details on back.

44 Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	260.00
Policy No. 0108121	Division No. 001 4
Due Date 03/01/1999	Statement Date 02/16/1999

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 770-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		260.00
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	157.14	
(B) Amount Paid	157.14	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		260.00

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14411 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12636

03/01/1999

PAY TO THE ORDER OF Unum $ **260.00

Two Hundred Sixty and 00/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

22

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

TOTAL PREMIUM DUE	260.00
Policy No. 0108121	Division No. 001 4
Due Date 04/01/1999	Statement Date 03/19/1999

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

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For billing questions, please call (800) 421-0344

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SUMMARY OF PREMIUMS DUE

Current Period Premium	260.00
Adjustments to Prior Period's Premium	
Prior Period	
(A) Amount Billed	260.00
(B) Amount Paid	260.00
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	260.00

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14427 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12737

03/27/1999

PAY TO THE ORDER OF Unum $ **260.00

Two Hundred Sixty and 00/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

27

MEMO 0108121

REDACTED

Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UM

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	260.00
Policy No. 0108121	Division No. 001 4
Due Date 05/01/1999	Statement Date 04/19/1999

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

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Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		260.00
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	260.00	
(B) Amount Paid	260.00	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		260.00

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14427 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12843

RECEIVED IN
ENV. #33223

05/01/1999

PAY TO THE ORDER OF Unum

$ **260.00

Two Hundred Sixty and 00/100********** DOLLARS

Security features included. Details on back

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	260.00
Policy No. 0108121	Division No. 001 4
Due Date 06/01/1999	Statement Date 05/19/1999

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12934

05/28/1999

PAY TO THE ORDER OF Unum

RECEIVED IN 33223

$ **260.00

Two Hundred Sixty and 00/100********** DOLLARS

Security features included Details on back

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT S

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	260.00
Policy No. 0108121	Division No. 001 4
Due Date 07/01/1999	Statement Date 06/18/1999

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Paid

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Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	260.00
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed 260.00 (B) Amount Paid 260.00	
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	260.00

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14410 04 N

Please remit this page with your payment.

Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (in Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Policy No. 0108121 Division No. 001 4

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	T , Jamie L		6/30/72	6/7/99	7/1/05	3410	340.00 per week

00010002903890116274

REDACTED

UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108124	001	Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
T	Jamie	L.	

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked
06,30,1977	06,04,1999	☒ F ☐ M	$ 8.50/hr	☐ Weekly ☐ Monthly ☐ Annually	Weekly 40

11. Occupation/Title: Receptionist

12. Your employer will inform you of available coverages. Check no if you decline or coverage is not available.

Life/AD&D	☐ Yes	☒ No	LTD	☐ Yes	☒ No
STD	☐ Yes	☒ No	Dependent Life	☐ Yes	☒ No

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship
C	Phyllis	L.	mother

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Jamie T Date: 06,26,1999

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	___/___/_____	____ STD	___/___/_____
____ Dep Life	___/___/_____	____ LTD	___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) **UNUM COPY**

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13036

06/26/1999

PAY TO THE ORDER OF Unum $ **260.00

Two Hundred Sixty and 00/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT T

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

TOTAL PREMIUM DUE	267.37
Policy No. 0108121	Division No. 001 4
Due Date 08/01/1999	Statement Date 07/19/1999

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	267.37
Adjustments to Prior Period's Premium	
Prior Period	
(A) Amount Billed	260.00
(B) Amount Paid	260.00
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	267.37

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	M Jennifer		5/4/75		7/31/99		
A	Y Audrey		10/20/47	7/20/99	8/1/99		460.00 per week

K6-14410 04 N

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REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13131

07/31/1999

PAY TO THE ORDER OF Unum $ **267.37

Two Hundred Sixty-Seven and 37/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

36

MEMO 0108121

REDACTED

EXHIBIT U

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	306.55
Policy No. 0108121	Division No. 001 4
Due Date 09/01/1999	Statement Date 08/19/1999

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		312.62
Adjustments to Prior Period's Premium		-6.07
Prior Period		
(A) Amount Billed	267.37	
(B) Amount Paid	267.37	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		306.55

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	Jamie				8/24/99		

K6-14418 04 N

Please remit this page with your payment.

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13234

09/03/1999

PAY TO THE ORDER OF Unum $ **306.55

Three Hundred Six and 55/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

MP

REDACTED

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	619.17
Policy No. 0108121	Division No. 001 4
Due Date 10/01/1999	Statement Date 09/07/1999

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	312.62
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed 306.55 (B) Amount Paid	
Balance from Prior Period (A-B)	306.55
TOTAL PREMIUM DUE	619.17

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14410 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13301

09/20/1999

PAY TO THE ORDER OF Unum $ **312.62

Three Hundred Twelve and 62/100********** DOLLARS

Security features included
Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	290.51
Policy No. 0108121	Division No. 001 4
Due Date 11/01/1999	Statement Date 10/05/1999

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1083 WILLOW PASS RD
CONCORD CA 94520

Fold

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Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		305.25
Adjustments to Prior Period's Premium		-14.74
Prior Period		
(A) Amount Billed	619.17	
(B) Amount Paid	619.17	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		290.51

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14410 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13380

10/15/1999

PAY TO THE ORDER OF Unum $ **290.51

Two Hundred Ninety and 51/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	595.76
Policy No. 0108121	Division No. 001 4
Due Date 12/01/1999	Statement Date 11/04/1999

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Paid

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Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		305.25
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed	290.51	
(B) Amount Paid		
Balance from Prior Period (A-B)		290.51
TOTAL PREMIUM DUE		595.76

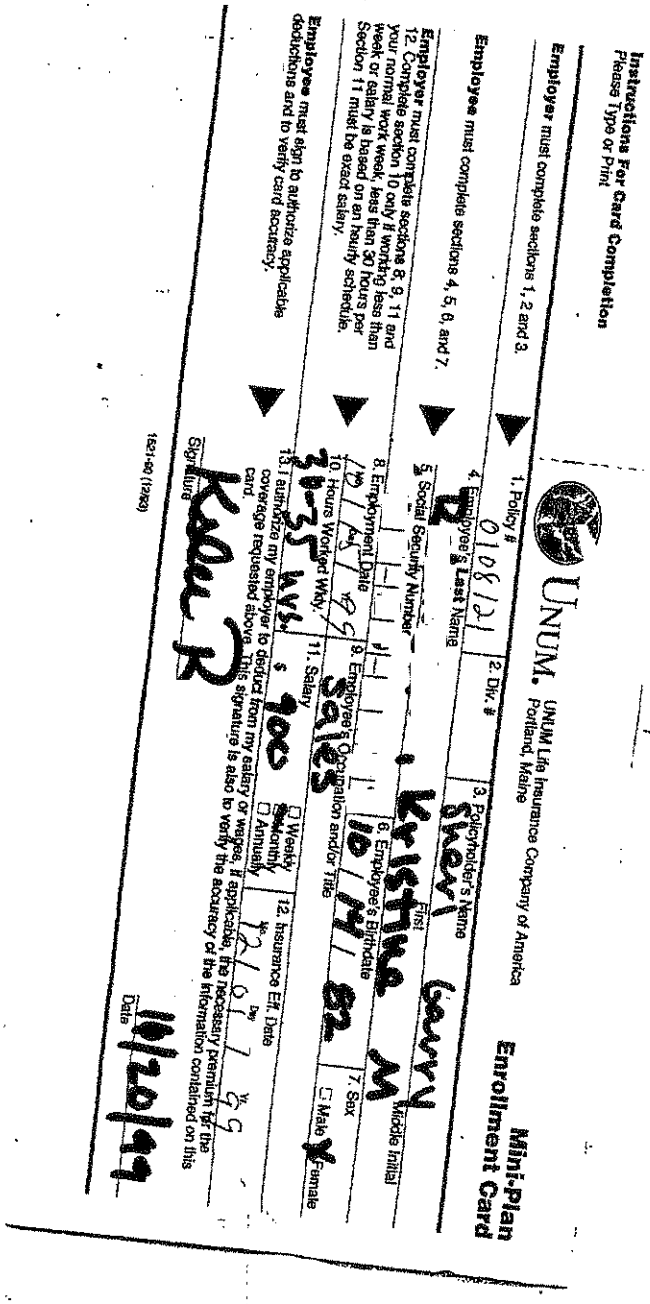
Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
O A	Y Audrey R Kristina		10/20/47 10/14/82	7/20/99 10/5/99	11/20/99 (Part time 2 days a week only) → 12/01/99		

K6-14419 04 N

Please remit this page with your payment.

REDACTED



Instructions For Card Completion
Please Type or Print

Employer must complete sections 1, 2 and 3.

Employee must complete sections 4, 5, 6, and 7.

Employer must complete sections 8, 9, 11 and 12. Complete section 10 only if working less than your normal work week; less than 30 hours per week or salary is based on an hourly schedule. Section 11 must be exact salary.

Employee must sign to authorize applicable deductions and to verify card accuracy.

UNUM. UNUM Life Insurance Company of America
Portland, Maine

Mini-Plan Enrollment Card

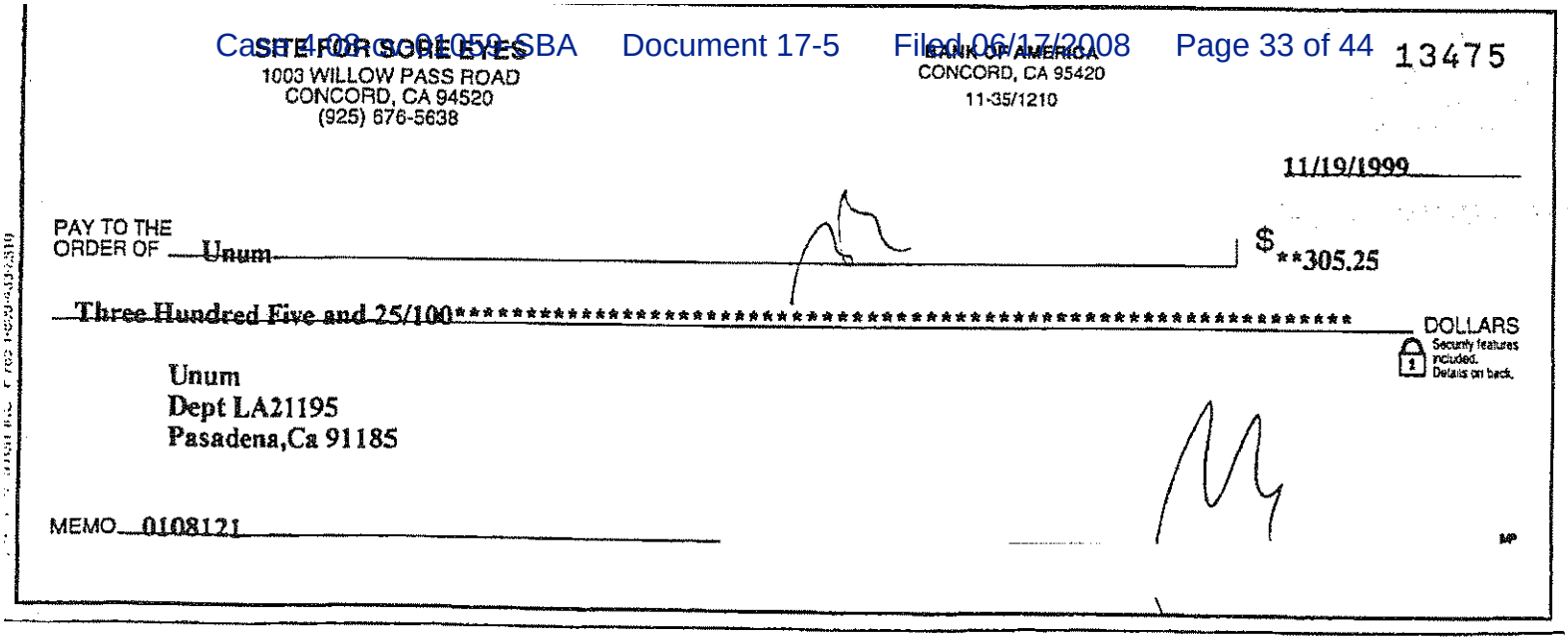
1. Policy # 0 1 0 8 1 2 1
2. Div. #
3. Policyholder's Name Shaw's
4. Employee's Last Name H
First Kristine
Middle Initial M
5. Social Security Number - -
6. Employee's Birthdate 10 / 14 / 82
7. Sex ☐ Male ☐ Female
8. Employment Date / /
9. Employee's Occupation and/or Title Sales
10. Hours Worked Wkly 35 Wks
11. Salary $ 700 ☐ Weekly ☐ Monthly ☐ Annually
12. Insurance Eff. Date 10 / 01 / 99

13. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature is also to verify the accuracy of the information contained on this card.

Signature Kim R
Date 10/20/99

152-90 (12/93)

REDACTED



SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13475

11/19/1999

PAY TO THE ORDER OF Unum $**305.25

Three Hundred Five and 25/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

MP

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13578

12/28/1999

PAY TO THE ORDER OF Unum $ **183.64

One Hundred Eighty-Three and 64/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

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UNUM

UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108121		Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
C	Daisy	R	

6. Birthdate	7. Employment Date	8. Sex	9. Salary	10. Hours Worked
01/17/1970	12/21/1999	☐ F ☐ M	$12.50 hr ☐ Weekly ☑ Monthly ☐ Annually	Weekly 40

11. Occupation/Title	12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.			
Optician	Life/AD&D	☐ Yes ☐ No	LTD	☐ Yes ☐ No
	STD	☐ Yes ☐ No	Dependent Life	☐ Yes ☐ No

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature [redacted] Date: 12/21/1999

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	2/1/00	____ STD	/ /
____ Dep Life	/ /	____ LTD	/ /

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98)

EMPLOYEE COPY

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	230.46
Policy No. 0108121	Division No. 001 4
Due Date 02/01/2000	Statement Date 01/05/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	230.46
Adjustments to Prior Period's Premium	
Prior Period	
(A) Amount Billed	183.64
(B) Amount Paid	183.64
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	230.46

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K5-14427 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13680

01/31/2000

PAY TO THE ORDER OF Unum $ **230.46

Two Hundred Thirty and 46/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT V

Provident Life and Accident Insurance Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	427.77
Policy No. 0108121	Division No. 001 4
Due Date 03/01/2000	Statement Date 02/03/2000

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-8730. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	219.41
Adjustments to Prior Period's Premium	-22.18
Prior Period (A) Amount Billed 230.46 (B) Amount Paid	
Balance from Prior Period (A-B)	230.46
TOTAL PREMIUM DUE	427.77

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	C Daisy		01/17/70	12/2/00	2/1/00		500.00 per week

K6-14427 84 N

Please remit this page with your payment.

REDACTED

13731

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

02/09/2000

PAY TO THE ORDER OF Unum $ **219.41

Two Hundred Nineteen and 41/100********** DOLLARS

Security features included
Details on back

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	197.31
Policy No. 0108121	Division No. 001 4
Due Date 04/01/2000	Statement Date 03/06/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1083 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		219.41
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	427.77	
(B) Amount Paid	449.87	
Balance from Prior Period (A-B)		-22.10
TOTAL PREMIUM DUE		197.31

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A C	Daisy		01/17/70	01/2000	02/2000		5000 per week

K6-14439 04 N

Please remit this page with your payment.

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13845

03/17/2000

PAY TO THE ORDER OF Unum $ **197.31

One Hundred Ninety-Seven and 31/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	219.41
Policy No. 0108121	Division No. 001 4
Due Date 05/01/2000	Statement Date 04/04/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		219.41
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	197.31	
(B) Amount Paid	197.31	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		219.41

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14439 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

13961

04/21/2000

PAY TO THE ORDER OF Unum $**219.41

Two Hundred Nineteen and 41/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

RECEIVED IN ENV. $ 33222

MEMO 0108121

REDACTED

EXHIBIT W

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	438.82
Policy No. 0108121	Division No. 001 4
Due Date 06/01/2000	Statement Date 05/05/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		219.41
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed (B) Amount Paid	219.41	
Balance from Prior Period (A-B)		219.41
TOTAL PREMIUM DUE		438.82

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14439 04 N

Please remit this page with your payment.

Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (In Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Policy No. 0108121 Division No. 001 4

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	Melana		9/6/1980	4/4/00	5/4/00		8.50 per hour

00010002003KT001837Y

REDACTED

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UNUM

UNUM Life Insurance Company of America
Portland, Maine 04122-1870

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
010812		Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
G	MELANA	J	

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked Weekly
09/06/1980	4/24/00	☒ F ☐ M	$ 8.50	☐ Weekly ☐ Monthly ☐ Annually	40

11. Occupation/Title: RECEPTIONIST

12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.

Life/AD&D	☐ Yes ☐ No	LTD	☐ Yes ☐ No		
STD	☐ Yes ☐ No	Dependent Life	☐ Yes ☐ No		

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship
R	NICHOLAS	R	

• To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Melana J Date: 05/16/2000

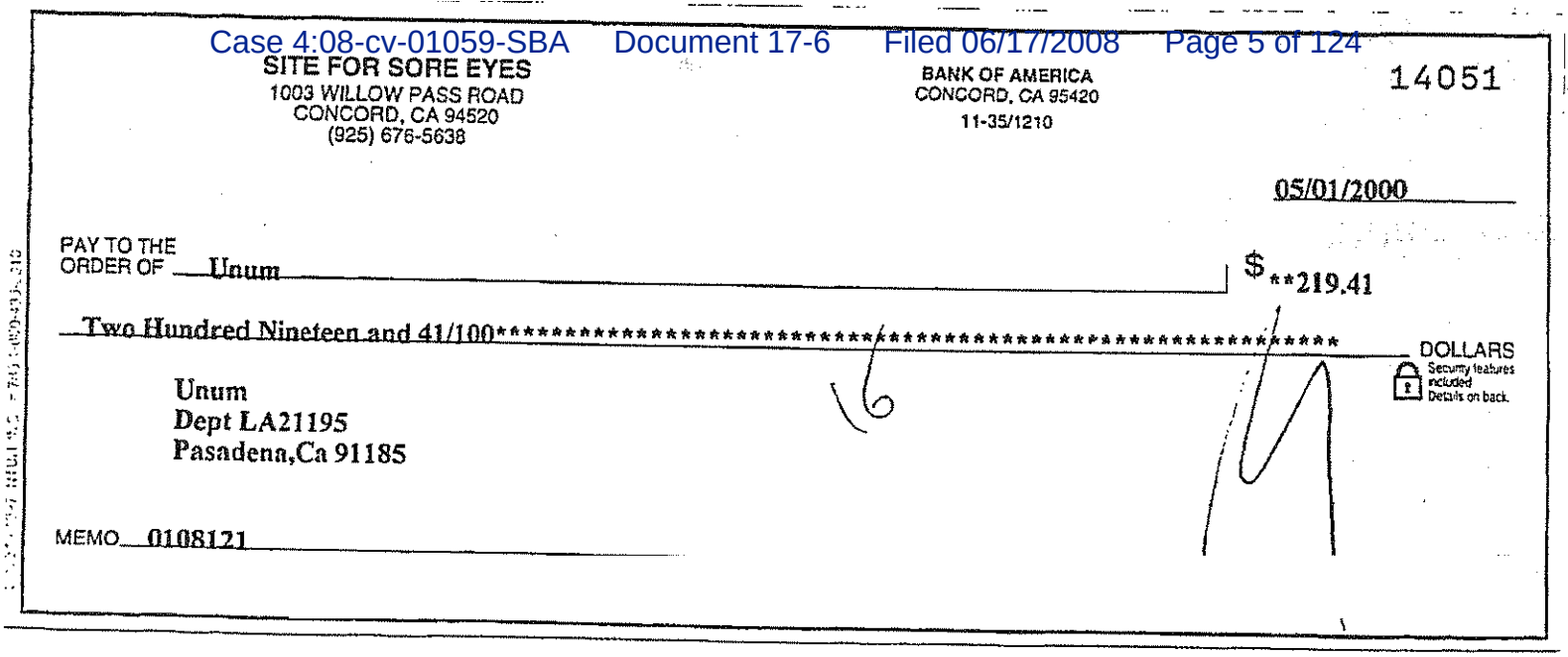
16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-81 (2/98) **EMPLOYEE COPY**

REDACTED



SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14051

05/01/2000

PAY TO THE ORDER OF Unum $ **219.41

Two Hundred Nineteen and 41/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

16

REDACTED

EXHIBIT X

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	581.21
Policy No. 0108121	Division No. 001 4
Due Date 07/01/2000	Statement Date 06/05/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
1003 WILLOW PASS RD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		241.30
Adjustments to Prior Period's Premium		120.50
Prior Period		
(A) Amount Billed	438.82	
(B) Amount Paid	219.41	
Balance from Prior Period (A-B)		219.41
TOTAL PREMIUM DUE		581.21

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	S Paul		10/24/70		6/8/00 (last day)		

K6-14439 04 N

Please remit this page with your payment.

REDACTED

Dear Vender Unum:

Acc. # 0108121

We are not moving but as of August 1st our address is changing to 901 Sunvalley Blvd. 94520 our telephone number will remain the same.

Thank You,
Site For Sore Eyes
901 Sunvalley Blvd.
Concord, Ca 94520

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14124

06/13/2000

PAY TO THE ORDER OF Unum $**438.82

Four Hundred Thirty-Eight and 82/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT Y

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	164.29
Policy No. 0108121	Division No. 001 4
Due Date 08/01/2000	Statement Date 07/05/2000

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6730. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		237.62
Adjustments to Prior Period's Premium		5.69
Prior Period		
(A) Amount Billed	881.21	
(B) Amount Paid	658.23	
Balance from Prior Period (A-B)		-77.02
TOTAL PREMIUM DUE		164.29

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	K Donovan		12/21/67	06/30/00	08/01/00		3083.00 per month

K6-14439 04 N

Please remit this page with your payment.

REDACTED

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UNUM.

UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108121		Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
K	Damavan	A	

6. Birthdate	7. Employment Date	8. Sex	9. Salary	10. Hours Worked Weekly
12/12/1967	06/30/00	☐ F ☒ M	$3083.00 ☐ Weekly ☒ Monthly ☐ Annually	

11. Occupation/Title	12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.
Assistance Manager	Life/AD&D ☐ Yes ☐ No LTD ☐ Yes ☒ No STD ☐ Yes ☐ No Dependent Life ☐ Yes ☐ No

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship
Andrea K		C	Sister

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature Damavan K Date: 07/17/1900

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) EMPLOYEE COPY

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14244

07/18/2000

PAY TO THE ORDER OF Unum $ **164.29

One Hundred Sixty-Four and 29/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	237.62
Policy No. 0108121	Division No. 001 4
Due Date 09/01/2000	Statement Date 08/07/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6989. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		237.62
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	164.29	
(B) Amount Paid	164.29	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		237.62

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14439 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14369

08/28/2000

PAY TO THE ORDER OF Unum $**237.62

Two Hundred Thirty-Seven and 62/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT Z

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	283.88
Policy No. 0108121	Division No. 001 4
Due Date 10/01/2000	Statement Date 09/07/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Our fax number is (207) 575-6989. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		253.04
Adjustments to Prior Period's Premium		30.84
Prior Period		
(A) Amount Billed	237.62	
(B) Amount Paid	237.62	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		283.88

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	G Melana		9/6/80	4/4/00	9/20/00		

K6-14439 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14464

09/21/2000

PAY TO THE ORDER OF Unum $ **283.88

Two Hundred Eighty-Three and 88/100********** DOLLARS

Security features included. Details on back

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

MP

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UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	536.92
Policy No. 0108121	Division No. 001 4
Due Date 11/01/2000	Statement Date 10/05/2000

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Our fax number is (207) 575-8989. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
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Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	253.04
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed 283.88 (B) Amount Paid	
Balance from Prior Period (A-B)	283.88
TOTAL PREMIUM DUE	536.92

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	G Melana				9/31/00		
A	G Daisy						

K6-14427 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14544

10/23/2000

PAY TO THE ORDER OF Unum

$**253.04

Two Hundred Fifty-Three and 04/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

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EXHIBIT AA

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	230.93
Policy No. 0108121	Division No. 001 4
Due Date 12/01/2000	Statement Date 11/07/2000

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

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For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		245.67
Adjustments to Prior Period's Premium		-14.74
Prior Period		
(A) Amount Billed	536.92	
(B) Amount Paid	536.92	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		230.93

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	C Dasy		1/17/70	12/1/99	9/28/00		
			(2nd Request)				

K6-14409 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14642

11/20/2000

PAY TO THE ORDER OF Unum $ **230.93

Two Hundred Thirty and 93/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

13

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UNUM

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 01/01/2001 Statement Date 12/07/2000

SHERI A. GARAY DBA
SITE FOR SORE EYES

SUMMARY OF CURRENT PERIOD PREMIUMS FROM 01/01/2001 THROUGH 01/31/2001

MINI-PLAN LONG-TERM DISABILITY (M-LTD)		
EE'S WITH COVERAGE	5	
COVERAGE	17,743	
RATE	MULTIPLE	234.83
CURRENT PERIOD PREMIUM		234.83

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		234.83
Adjustments to Prior Period's Premium		-32.52
Prior Period (A) Amount Billed (B) Amount Paid	230.93	
Balance from Prior Period (A-B)		230.93
TOTAL PREMIUM DUE		433.24

IMPORTANT:
- Rates are shown on a monthly basis.
- Please verify balance due from prior period. Notify us of any discrepancies.

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

K6-14409 04 N

KEEP FOR YOUR RECORDS

UNUM

GROUP INSURANCE PREMIUM STATEMENT

PAGE 002

Policy No. 0108121
Due Date 01/01/2001

Division No. 001 4
Statement Date 12/07/2000

EMPLOYEE NAME / SOCIAL SECURITY NO.		M-LTD PREMIUM
C DAISY		-32.52
PREMIUM TOTALS		-32.52

SUMMARY OF ADJUSTMENTS

Any changes received after the statement date will be shown on the next bill.

A = Addition S = Salary Change CV = Coverage Change C = Class Change
T = Termination R = Reinstatement RT = Rate Change M = Multiple Changes

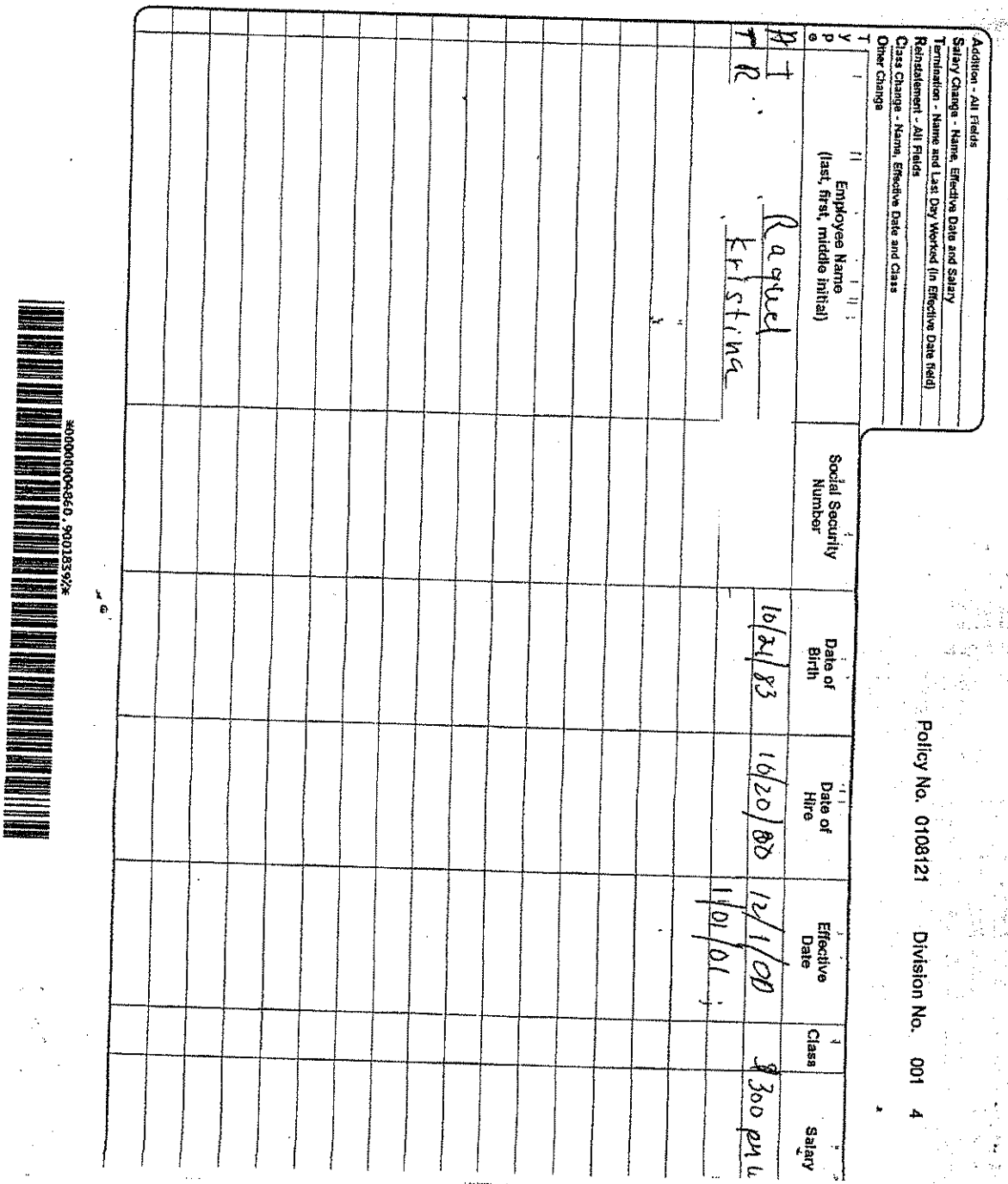
ADJUSTMENT CODE	NO DAYS	PREMIUM
T	3	-32.52
		-32.52

K6-14409 04 N

KEEP FOR YOUR RECORDS

0000000040860.900183%

REDACTED



Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (in Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Policy No. 0108121 Division No. 001 4

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
PT	Raquel Kristina		10/24/83	10/20/00	12/1/00	8300	$300 per w
PT					11/01/01		

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14740

12/20/2000

PAY TO THE ORDER OF Unum $ **230.93

Two Hundred Thirty and 93/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

MP

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EXHIBIT BB

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

01354

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	437.14
Policy No. 0108121	Division No. 001 4
Due Date 02/01/2001	Statement Date 01/09/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

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For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		234.83
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	433.24	
(B) Amount Paid	230.93	
Balance from Prior Period (A-B)		202.31
TOTAL PREMIUM DUE		437.14

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	R Kristina		10/14/84		01/01/01		

K6-14409 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
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BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14854

01/24/2001

PAY TO THE ORDER OF Unum $ **230.93

Two Hundred Thirty and 93/100********** DOLLARS

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Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

Declined 2.2.01
Veronica Herrera

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UNUM

UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0168121	001	Site for Sore Eyes

4. Employee's Last Name: H — First: Veronica — Middle Initial — 5. Social Security Number

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked Weekly
02/16/1967	01/23/2001	☒ F ☐ M	$15.00	☐ Weekly ☐ Monthly ☐ Annually	38

11. Occupation/Title: optician

12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.

Life/AD&D	☐ Yes	☑ No	LTD	☐ Yes	☑ No
STD	☐ Yes	☑ No	Dependent Life	☐ Yes	☑ No

13. Beneficiary(ies) Last Name — First — Middle Initial — 14. Relationship

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Veronica H — Date: 2/2/2001

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) EMPLOYEE COPY

Decline life insurance policy

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UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

01392

UNUM®

Group Insurance Premium Statement

TOTAL PREMIUM DUE	453.54
Policy No. 0108121	Division No. 001 4
Due Date 03/01/2001	Statement Date 02/06/2001

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD.
CONCORD CA 94520

222.61

Paid

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		236.83
Adjustments to Prior Period's Premium		10.50
Prior Period		
(A) Amount Billed	437.14	
(B) Amount Paid	230.93	
Balance from Prior Period (A-B)		206.21
TOTAL PREMIUM DUE		453.54

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14409 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

14956

02/28/2001

PAY TO THE ORDER OF Unum $ **222.61

Two Hundred Twenty-Two and 61/100********** DOLLARS

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Unum
Dept LA21195
Pasadena,Ca 91185

RECEIVED IN
DIV. 35223

MEMO 0108121

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EXHIBIT CC

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

01738

UNUM

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	459.44
Policy No. 0108121	Division No. 001 4
Due Date 04/01/2001	Statement Date 03/08/2001

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

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Our fax number is (207) 771-4039. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
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Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		236.83
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	453.54	
(B) Amount Paid	230.93	
Balance from Prior Period (A-B)		222.61
TOTAL PREMIUM DUE		459.44

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	~~Veronica~~		2/16/61	1/23/01	3/01/01		15.00 p/hr
I	Raquel				3/01/01		

K6-14489 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15027

03/16/2001

PAY TO THE ORDER OF Unum

$ **236.83

Two Hundred Thirty-Six and 83/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

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UNUM. UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
010812		Site for Sore Eyes

4. Employee's Last Name: D — First: FAYE — Middle Initial: — 5. Social Security Number: —

6. Birthdate: 11/26/1949 — 7. Employment Date: 4/01/01 — 8. Sex: ☒ F ☐ M — 9. Salary: $600 ☐ Weekly ☐ Monthly ☐ Annually — 10. Hours Worked Weekly: 40

11. Occupation/Title:

12. Your employer will inform you of available coverages. Check yes to enroll.
Check no if you decline or coverage is not available.
Life/AD&D ☐ Yes ☐ No — LTD ☐ Yes ☐ No
STD ☐ Yes ☐ No — Dependent Life ☐ Yes ☐ No

13. Beneficiary(ies) Last Name: D — First: JOHN — Middle Initial: — 14. Relationship: HUSBAND

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: [signature] Date: 03/27/2001

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
___ Life/AD&D	___/___/____	___ STD	___/___/____
___ Dep Life	___/___/____	___ LTD	___/___/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) EMPLOYEE COPY

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EXHIBIT DD

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

05160

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE		287.53
Policy No. 0108121	Division No.	001 4
Due Date 05/01/2001	Statement Date	04/09/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

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Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		253.73
Adjustments to Prior Period's Premium		33.80
Prior Period		
(A) Amount Billed	459.44	
(B) Amount Paid	459.44	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		287.53

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	H Veronica		2/16/1967		3/22/01		

K6-14409 04 H

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15144

04/23/2001

PAY TO THE ORDER OF Unum $ **287.53

Two Hundred Eighty-Seven and 53/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

MP

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EXHIBIT EE

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

01868

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	183.53
Policy No. 0108121	Division No. 001 4
Due Date 06/01/2001	Statement Date 05/09/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

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Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		250.33
Adjustments to Prior Period's Premium		-66.80
Prior Period		
(A) Amount Billed	287.53	
(B) Amount Paid	287.53	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		183.53

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
A	D Faye		11/26/49	03/27/01	05/01/01		600.00 per week

K6-14409 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15225

49

05/22/2001

PAY TO THE ORDER OF Unum

$ **183.53

One Hundred Eighty-Three and 53/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

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UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

04824

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	431.18
Policy No. 0108121	Division No. 001 4
Due Date 07/01/2001	Statement Date 06/08/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

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Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium		297.28
Adjustments to Prior Period's Premium		133.90
Prior Period		
(A) Amount Billed	183.53	
(B) Amount Paid	183.53	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		431.18

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary

K6-14404 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15328

06/29/2001

PAY TO THE ORDER OF Unum $ **431.18

Four Hundred Thirty-One and 18/100********** DOLLARS

Security features included. Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT FF

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

02531

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

TOTAL PREMIUM DUE	728.46
Policy No. 0108121	Division No. 001 4
Due Date 08/01/2001	Statement Date 07/09/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

SUMMARY OF PREMIUMS DUE

Current Period Premium	297.28
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed (B) Amount Paid 431.18	
Balance from Prior Period (A-B)	431.18
TOTAL PREMIUM DUE	728.46

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
T	D Faye				07/01/01		

K6-14409 04 N

Please remit this page with your payment.

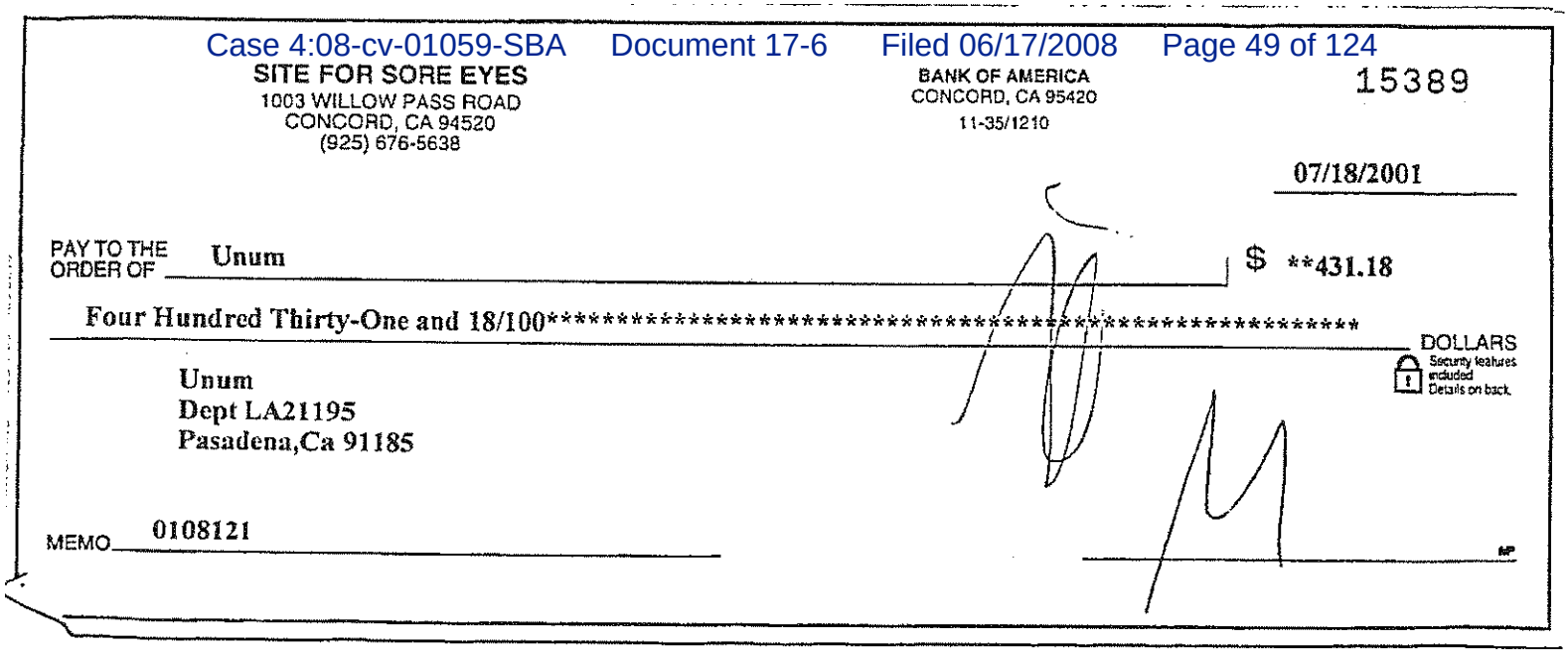
REDACTED

Addition - All Fields
Salary Change - Name, Effective Date and Salary
Termination - Name and Last Day Worked (In Effective Date field)
Reinstatement - All Fields
Class Change - Name, Effective Date and Class
Other Change

Policy No. 0108121 Division No. 001 4

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Class	Salary
D	Faye				7/1/01		

REDACTED



SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15389

07/18/2001

PAY TO THE ORDER OF Unum

$ **431.18

Four Hundred Thirty-One and 18/100********** DOLLARS

Security features included Details on back.

Unum
Dept LA21195
Pasadena,Ca 91185

MEMO 0108121

REDACTED

EXHIBIT GG

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

02055

UNUM

Group Insurance Premium Statement

TOTAL PREMIUM DUE	201.86
Policy No. 0108121	Division No. 001 4
Due Date 10/01/2001	Statement Date 09/07/2001

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
981 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium	239.33
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed. (B) Amount Paid	-37.47
Balance from Prior Period (A-B)	-37.47
TOTAL PREMIUM DUE	201.86

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T L	Richard				10/1/01			
T E	Donovan				10/1/01			
A H	Wilhelm		7/22/1973	8/1/01	9/1/01			
A C	Christina		09/10/1968	9/4/01	10/4/01			

K6-14411 04 N

Please remit this page with your payment.

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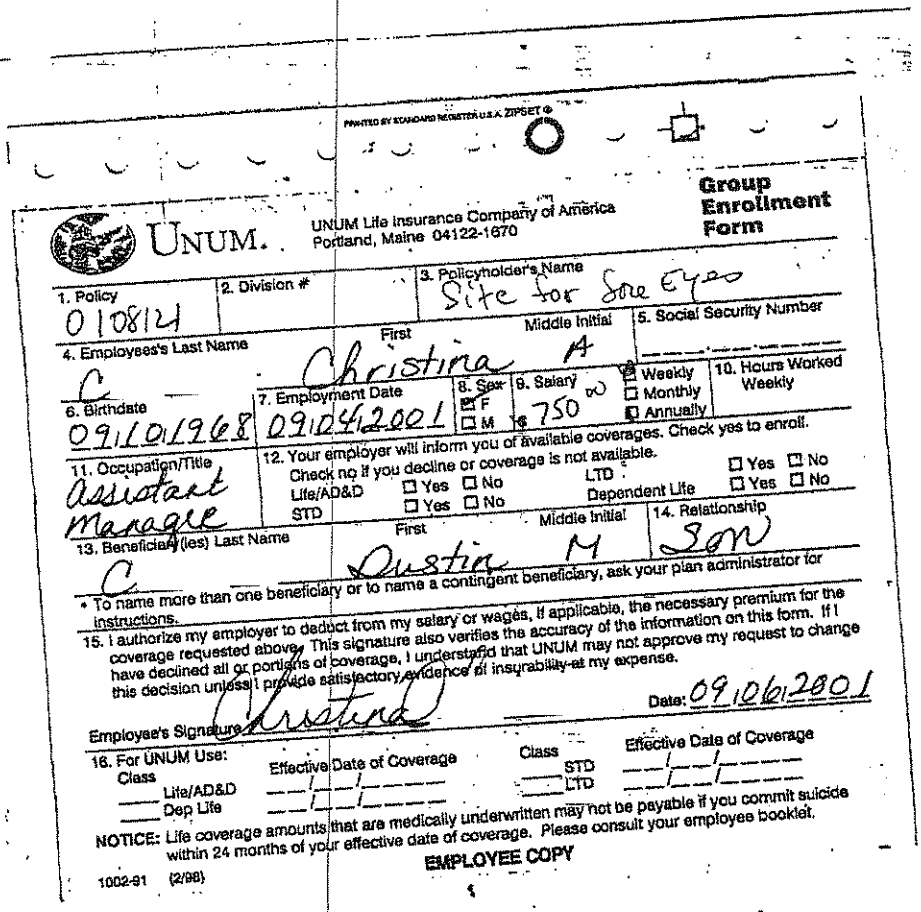


UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy: 010814
2. Division #:
3. Policyholder's Name: Site for Sore Eyes
4. Employee's Last Name: C — First: Christina — Middle Initial: A
5. Social Security Number: ___-___-____
6. Birthdate: 09/01/1968
7. Employment Date: 09/04/2001
8. Sex: ☑ F ☐ M
9. Salary: $ 750.00 ☐ Weekly ☐ Monthly ☐ Annually
10. Hours Worked Weekly:
11. Occupation/Title: Assistant Manager
12. Your employer will inform you of available coverages. Check yes to enroll.
Check no if you decline or coverage is not available.
Life/AD&D ☐ Yes ☐ No
STD ☐ Yes ☐ No
LTD ☐ Yes ☐ No
Dependent Life ☐ Yes ☐ No
13. Beneficiary(ies) Last Name: C — First: Dustin — Middle Initial: M
14. Relationship: Son

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Christina C — Date: 09/06/2001

16. For UNUM Use:
Class ____ Life/AD&D ____ Dep Life — Effective Date of Coverage ___/___/_____
Class ____ STD ____ LTD — Effective Date of Coverage ___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

EMPLOYEE COPY

1002-91 (2/98)

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15538

09/21/2001

PAY TO THE ORDER OF Unum $ **201.86

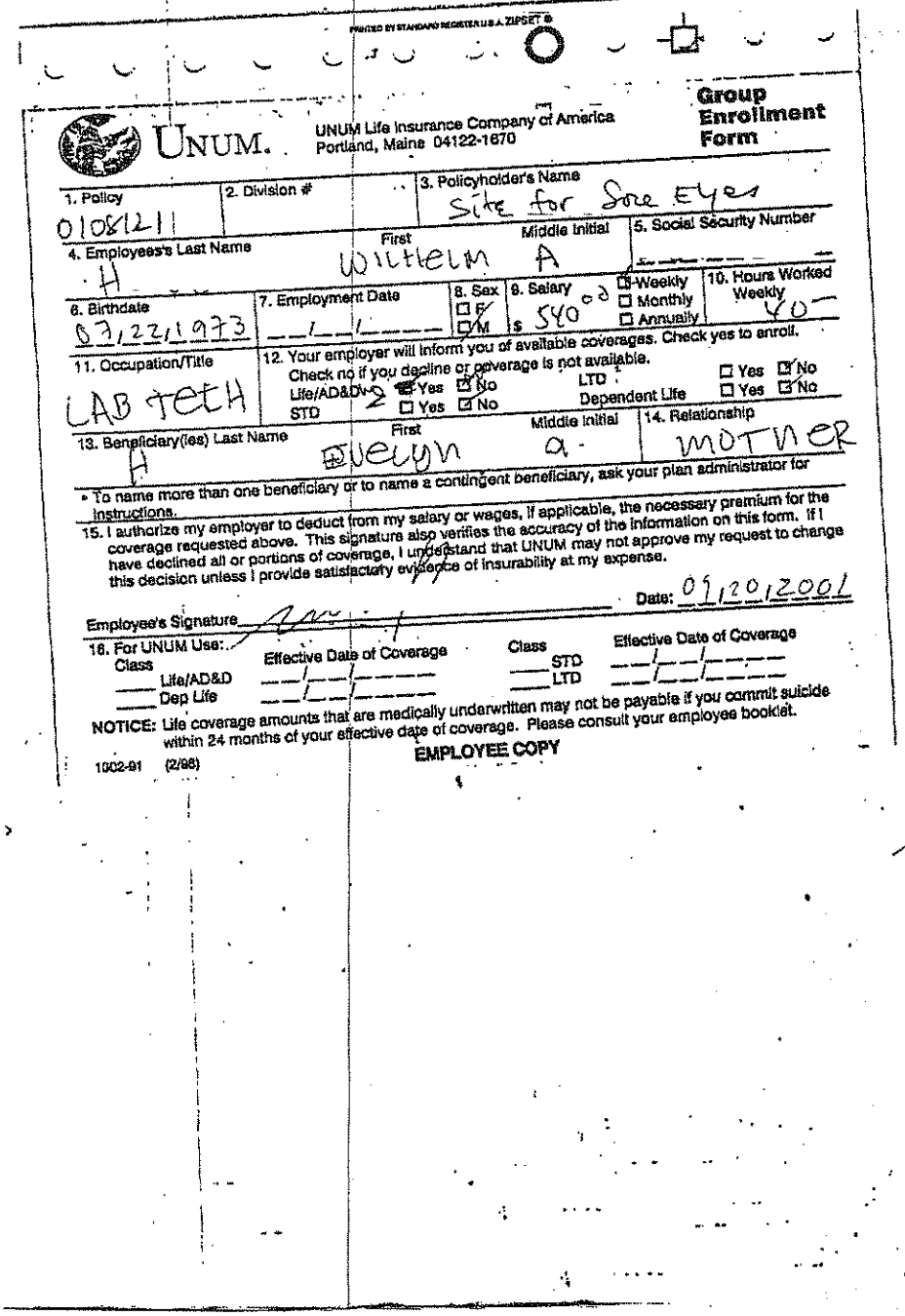
Two Hundred One and 86/100********** DOLLARS

Security features included Details on back.

Unum
33223 Treasury Center
Chicago, Ill 60694-3200

MEMO 0108121

REDACTED



UNUM Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108121		Site for Sore Eyes

4. Employee's Last Name: H — First: Wilhelm — Middle Initial: A — 5. Social Security Number: [redacted]

6. Birthdate: 07,22,1973 — 7. Employment Date: __/__/____ — 8. Sex: ☐ F ☑ M — 9. Salary: $ 540.00 ☐ Weekly ☐ Monthly ☐ Annually — 10. Hours Worked Weekly: 40

11. Occupation/Title: LAB TECH

12. Your employer will inform you of available coverages. Check yes to enroll.
Check no if you decline or coverage is not available.

Life/AD&D	☑ Yes ☐ No	LTD	☐ Yes ☑ No	Dependent Life	☐ Yes ☑ No
STD	☐ Yes ☑ No				

13. Beneficiary(ies) Last Name: H — First: Evelyn — Middle Initial: A. — 14. Relationship: MOTHER

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: [signature] Date: 01,20,2001

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	__/__/____	____ STD	__/__/____
____ Dep Life	__/__/____	____ LTD	__/__/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1902-91 (2/98) EMPLOYEE COPY

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

01972

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	134.84
Policy No. 0108121	Division No. 001 4
Due Date 11/01/2001	Statement Date 10/09/2001

UNUM LIFE INSURANCE
COMPANY OF AMERICA
33223 TREASURY CENTER
CHICAGO IL 60694-3200

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		189.36
Adjustments to Prior Period's Premium		-54.52
Prior Period		
(A) Amount Billed	201.86	
(B) Amount Paid	201.86	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		134.84

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-I4408 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15626

10/22/2001

PAY TO THE ORDER OF Unum $ **134.84

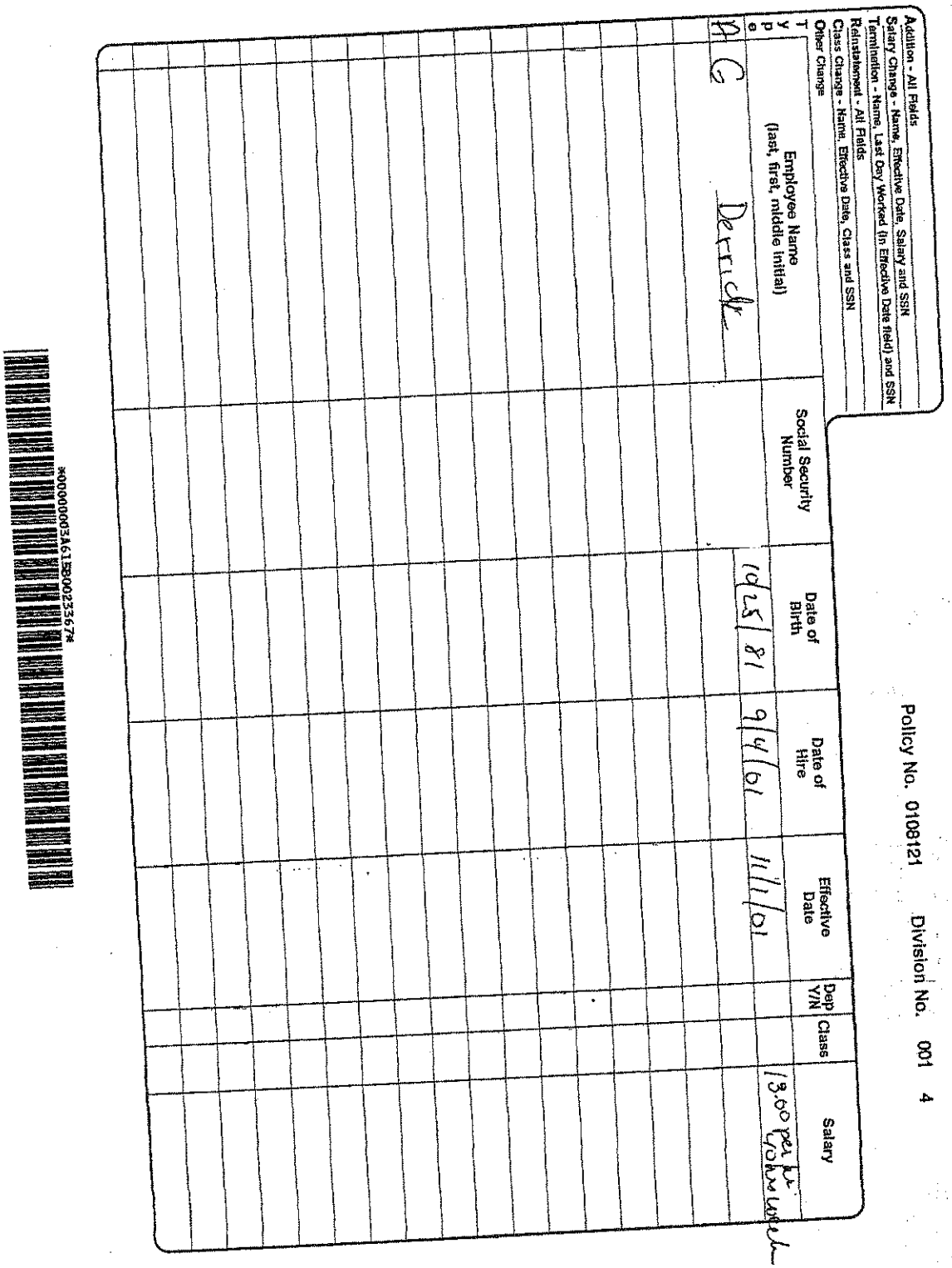
One Hundred Thirty-Four and 84/100********** DOLLARS

Security features included Details on back

Unum
33223 Treasury Center
Chicago, Ill 60694-3200

MEMO 0108121

REDACTED


Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (in Effective Date field) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change
Type
Employee Name (last, first, middle initial)
Social Security Number
Date of Birth
Date of Hire
Effective Date
Dep Y/N
Class
Salary
A C
Derrick
10/25/81
9/4/01
11/1/01
13.00 per hr
Policy No. 0108121
Division No. 001 4

REDACTED

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136
Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE. It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
G	Deedrick	T	
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
			10/25/81
City	State	Zip Code	Social Security #
Pittsburgh	CA	94565	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):
- ☒ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A _____)
- ☐ An alien authorized to work until ____/____/____ (Alien # or Admission # _____)

Employee's Signature [signature] Date (month/day/year) 9/22/09

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B **and** one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date (if any): ____/____/____		____/____/____		____/____/____
Document #:				
Expiration Date (if any): ____/____/____				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ____/____/____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name | Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)* | B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

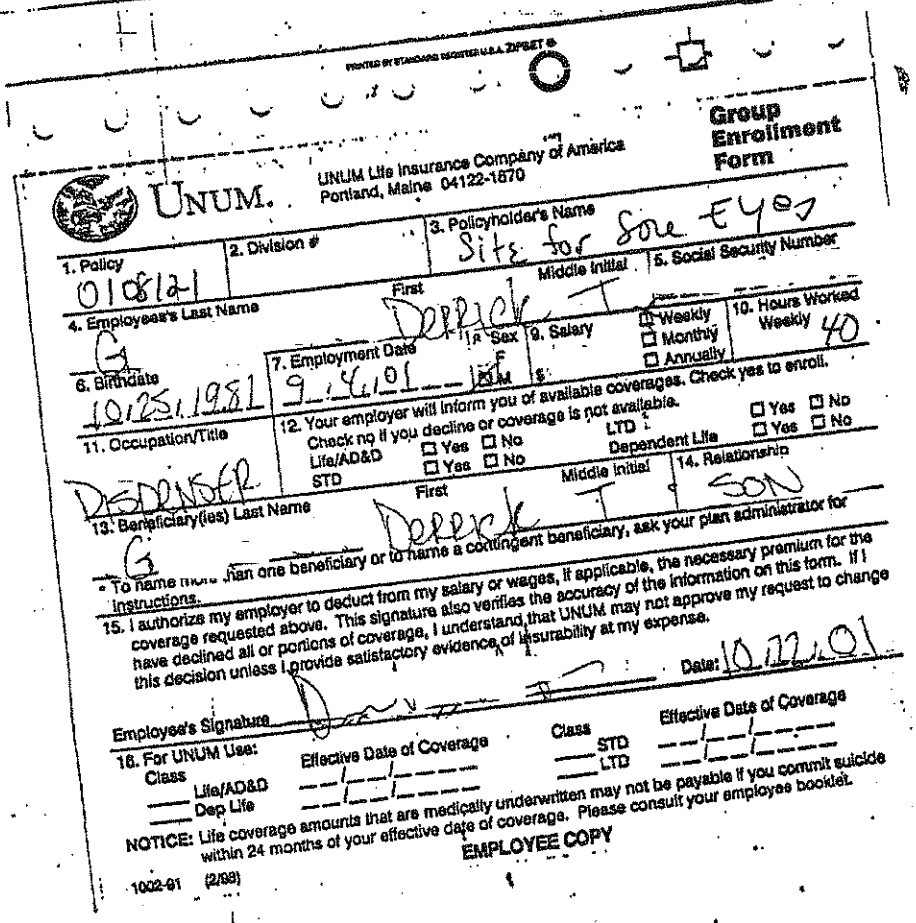
Document Title: _____ Document #: _____ Expiration Date (if any): ____/____/____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s) the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date (month/day/year)

Form I-9 (Rev. 11-21-91) N

REDACTED



UNUM Life Insurance Company of America
Portland, Maine 04122-1870

Group Enrollment Form

1. Policy 0108121
2. Division #
3. Policyholder's Name Sites for Sore Eyes
4. Employee's Last Name [redacted] First Derrick Middle Initial T
5. Social Security Number [redacted]
6. Birthdate 10/25/1981
7. Employment Date 9/6/01
8. Sex M
9. Salary $
10. Hours Worked Weekly 40 ☐ Weekly ☐ Monthly ☐ Annually
11. Occupation/Title
12. Your employer will inform you of available coverages. Check yes to enroll.
Check no if you decline or coverage is not available.
Life/AD&D ☐ Yes ☐ No
STD ☐ Yes ☐ No
LTD ☐ Yes ☐ No
Dependent Life ☐ Yes ☐ No
13. Beneficiary(ies) Last Name [redacted] First Derrick Middle Initial T
14. Relationship SON

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature [redacted] Date: 10.22.01

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
___ Life/AD&D	___/___/_____	___ STD	___/___/_____
___ Dep Life	___/___/_____	___ LTD	___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

EMPLOYEE COPY

1002-91 (2/99)

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

02206

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	324.20
Policy No. 0108121	Division No. 001 4
Due Date 12/01/2001	Statement Date 11/08/2001

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Paid

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

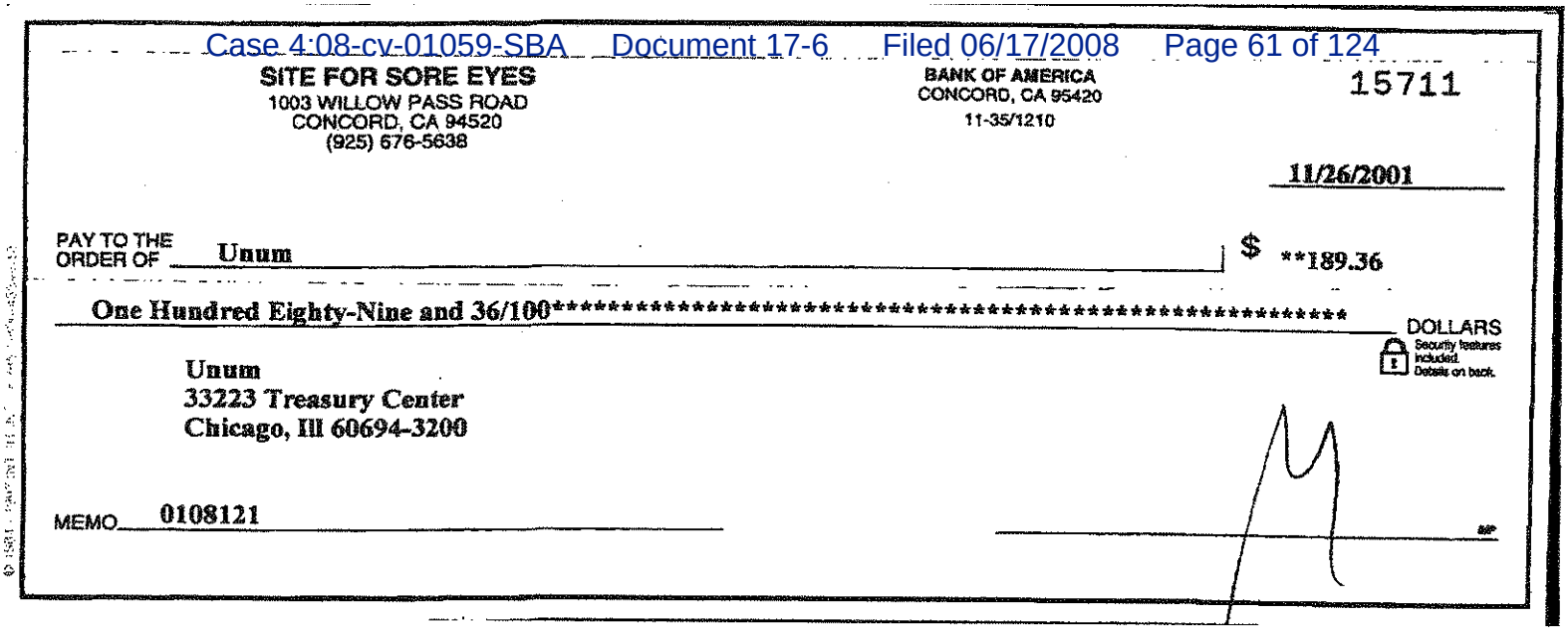
Current Period Premium		189.36
Adjustments to Prior Period's Premium		
Prior Period (A) Amount Billed	134.84	
(B) Amount Paid		
Balance from Prior Period (A-B)		134.84
TOTAL PREMIUM DUE		324.20

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14408 04 N

Please remit this page with your payment.



SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15711

11/26/2001

PAY TO THE ORDER OF Unum $ **189.36

One Hundred Eighty-Nine and 36/100********** DOLLARS

Security features included. Details on back.

Unum
33223 Treasury Center
Chicago, Ill 60694-3200

MEMO 0108121

REDACTED

EXHIBIT HH

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

05187

UNUM

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE 223.17

Policy No. 0108121 | Division No. 001 4

Due Date 01/01/2002 | Statement Date 12/10/2001

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed

SUMMARY OF PREMIUMS DUE

Current Period Premium		200.63
Adjustments to Prior Period's Premium		22.54
Prior Period		
(A) Amount Billed	324.20	
(B) Amount Paid	324.20	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		223.17

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other - Specify

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T								

K6-14408 04 N

Please remit this page with your payment.

REDACTED

Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

000588

UNUM®

Group Insurance Premium Statement

Please Remit To:

TOTAL PREMIUM DUE	200.63
Policy No. 0108121	Division No. 001 4
Due Date 02/01/2002	Statement Date 01/10/2002

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

lease pay as billed. Adjustments for
hanges received prior to the statement
ate are reflected on this bill.

For billing questions, please call
(800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		200.63
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	223.17	
(B) Amount Paid	223.17	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		200.63

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security	Date of	Date of	Effecti

REDACTED

K6-14408 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15876

01/21/2002

PAY TO THE ORDER OF Unum $ **200.63

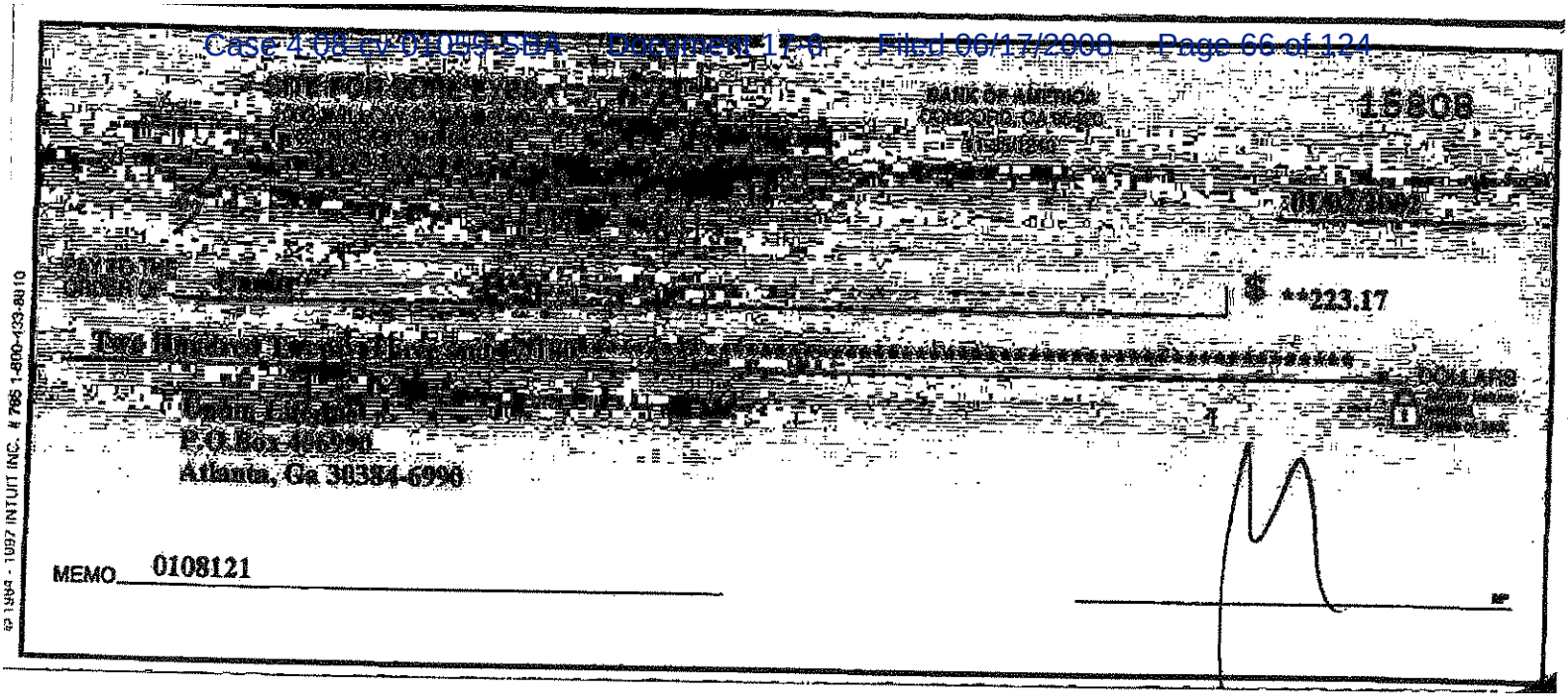
Two Hundred and 63/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED


BANK OF AMERICA
CRESCENT CITY, CA 95531
1580B
$ **223.17
Two Hundred Twenty-Three and 17/100*********
Union Electric
P O Box 66890
Atlanta, Ga 30384-6990
MEMO 0108121
© 1994 - 1997 INTUIT INC. # 765 1-800-433-8810

REDACTED

EXHIBIT II

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

00816

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	129.34
Policy No. 0108121	Division No. 001 4
Due Date 03/01/2002	Statement Date 02/07/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to **expedite adjustments** to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium	173.11
Adjustments to Prior Period's Premium	-43.77
Prior Period (A) Amount Billed 200.63 (B) Amount Paid 200.63	
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	129.34

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
A	B Cecelia		7/21/64	2/6/02	3/6/02			
A	C Kay		12/31/77	12/3/01	2/1/02			

[redacted] 04 N

REDACTED

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

15946

02/12/2002

PAY TO THE ORDER OF Unum $ **173.11

One Hundred Seventy-Three and 11/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

EXHIBIT JJ

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

00665

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	188.88
Policy No. 0108121	Division No. 001 4
Due Date 04/01/2002	Statement Date 03/11/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		204.05
Adjustments to Prior Period's Premium		28.60
Prior Period		
(A) Amount Billed	129.34	
(B) Amount Paid	173.11	
Balance from Prior Period (A-B)		-43.77
TOTAL PREMIUM DUE		188.88

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	B Cecelia				4/1/02			

K6-14408 04 N

Please remit this page with your payment.

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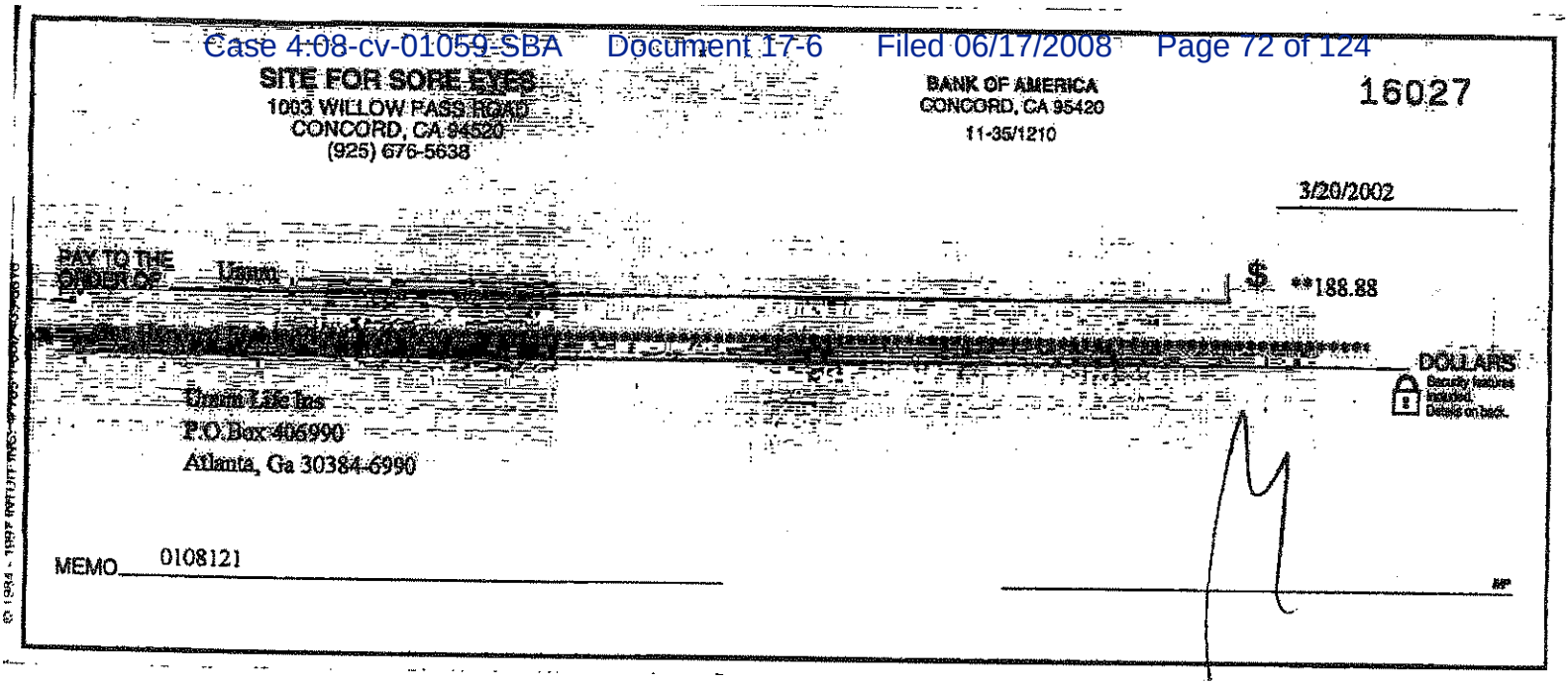

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

16027

3/20/2002

PAY TO THE ORDER OF Unum

$ **188.88

DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

00654

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	170.77
Policy No. 0108121	Division No. 001 4
Due Date 05/01/2002	Statement Date 04/09/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4039. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

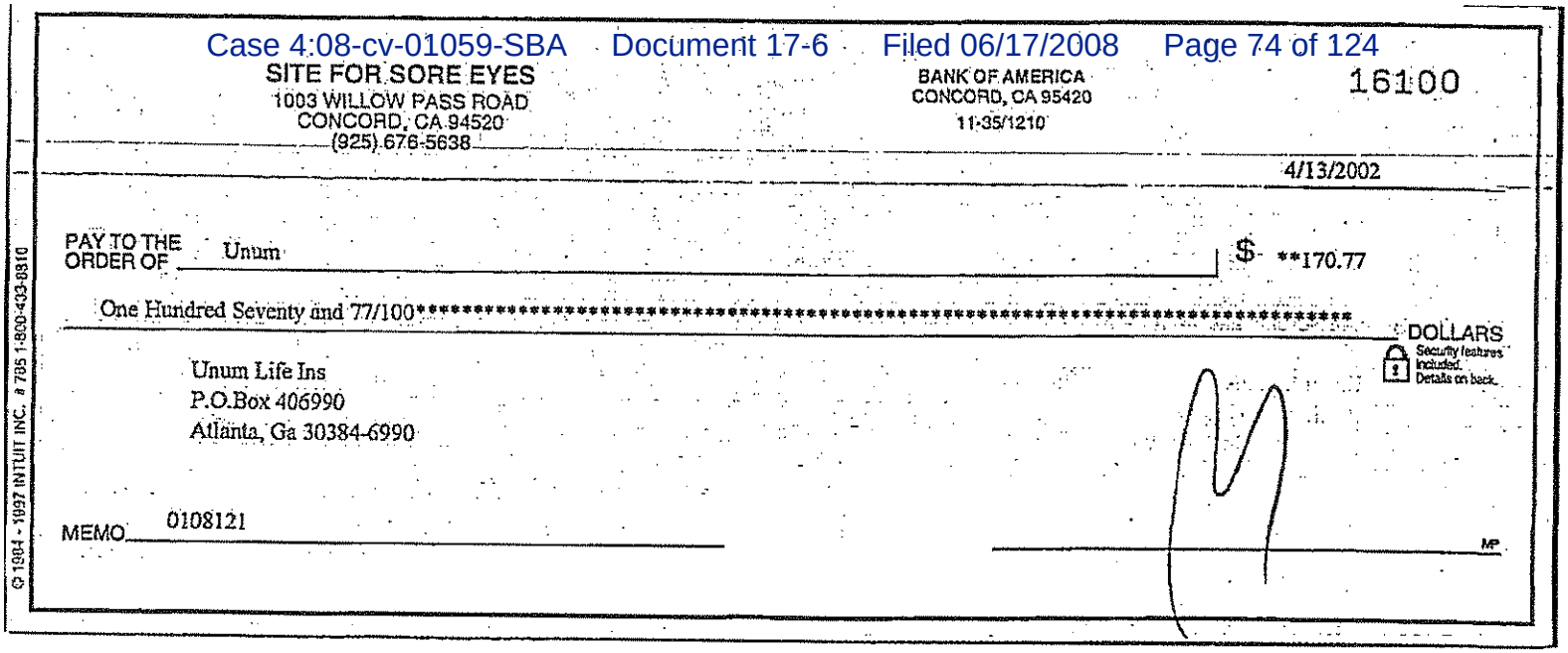
Current Period Premium		187.41
Adjustments to Prior Period's Premium		-16.64
Prior Period		
(A) Amount Billed	188.88	
(B) Amount Paid	188.88	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		170.77

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14408 04 N

Please remit this page with your payment.



SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

16100

4/13/2002

PAY TO THE ORDER OF Unum $ **170.77

One Hundred Seventy and 77/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

MP

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UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

06192

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	187.41
Policy No. 0108121	Division No. 001 4
Due Date 06/01/2002	Statement Date 05/10/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 541-7668. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		187.41
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	170.77	
(B) Amount Paid	170.77	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		187.41

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14811 04 N

Please remit this page with your payment.

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

16227

5/17/2002

PAY TO THE ORDER OF Unum $ **187.41

One Hundred Eighty-Seven and 41/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

EXHIBIT KK

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

06263

UNUM®

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX-406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	187.41
Policy No. 0108121	Division No. 001 4
Due Date 07/01/2002	Statement Date 06/10/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 541-7668. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium	187.41
Adjustments to Prior Period's Premium	
Prior Period	
(A) Amount Billed 187.41	
(B) Amount Paid 187.41	
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	187.41

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	C Stephanie				07/01/02			

K6-14811 04 N

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SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

16284

6/17/2002

PAY TO THE ORDER OF Unum $ **187.41

One Hundred Eighty-Seven and 41/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

UNUM Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

03528

UNUM®

Group Insurance Premium Statement

Please Remit To

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	238.97
Policy No. 0108121	Division No. 001 4
Due Date 08/01/2002	Statement Date 07/10/2002

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call
(800) 421-0344

Fax Instructions:

Our fax number is (207) 541-7668. Additions / Changes may be faxed to expedite adjustments to your next bill (Please continue to return this form with your premium payment)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		253.27
Adjustments to Prior Period's Premium		-14.30
Prior Period		
(A) Amount Billed	187.41	
(B) Amount Paid	187.41	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		238.97

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Changes

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14805 04 N 78

SITE FOR SORE EYES
1003 WILLOW PASS ROAD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

16367

7/15/2002

PAY TO THE ORDER OF Unum $ **238.97

Two Hundred Thirty-Eight and 97/100********** DOLLARS

Security features included. Details on back.

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

EXHIBIT LL

Claimant Name: Sheri Garay Claim #: 1081100

PAGE 003

GROUP INSURANCE PREMIUM STATEMENT

Policy No. 0108121 Division No. 001 4
Due Date 03/01/2003 Statement Date 02/07/2003

EMPLOYEE DETAIL

EMPLOYEE NAME SOCIAL SECURITY NO.		M-LTD COVERAGE	CURRENT PREMIUM*	ADJ CODE	ADJ DATE	SHOW EMPLOYEE ADJUSTMENTS HERE NEW ANNUAL SALARY
A	SHERRI	3333	30.00			
	GARAY,SHERI	30.00				
		8333				
H	KATHERINE N	1820	9.10			
		9.10				
R	STACY	3083	15.42			
		15.42				
S	DONALD W	3333	20.00			
		20.00				
T	NICHAEL	2917	26.25			
		26.25				

* Current premium due excluding adjustments - refer to adjustment page

KEEP FOR YOUR RECORDS

K6-1451 20 04 N

UNUM

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SCANNED

15 OF 15

UACL01615

FEB-18-2004 07:00 FROM:

TO:18778517624 P:15/15

UG-000208

EXHIBIT MM

UnumProvident

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

0229?

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE 1,045.51

Policy No. 0108121 Division No. 001 4

Due Date 05/01/2003 Statement Date 04/09/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Sherri Williams . Bzb

Paid

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018 Additions / Changes may be faxed to expedite adjustments to your next bill (Please continue to return this form with your premium payment.)
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SUMMARY OF PREMIUMS DUE

Current Period Premium	296.09
Adjustments to Prior Period's Premium	839.10
Prior Period	
(A) Amount Billed	-89.68
(B) Amount Paid	
Balance from Prior Period (A-B)	-89.68
TOTAL PREMIUM DUE	1,045.51

Addition - All Fields
Salary Change - Name Effective Date Salary and SSN
Termination - Name Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name Effective Date Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
D	H Catherine				5/1/03			

this Employee was terminated.

K6-14514 04 N 70

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17148

SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

4/25/2003

PAY TO THE ORDER OF Unum $ **1,045.51

One Thousand Forty-Five and 51/100**********DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

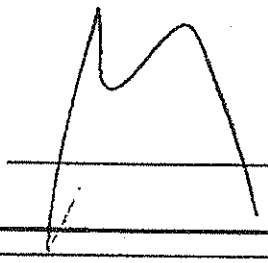

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EXHIBIT NN

UNUM PROVIDENT
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02283

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	277.89
Policy No. 0108121	Division No. 001 4
Due Date 06/01/2003	Statement Date 05/12/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Paid

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
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SUMMARY OF PREMIUMS DUE

Current Period Premium	286.99
Adjustments to Prior Period's Premium	-9.10
Prior Period	
(A) Amount Billed	1,045.51
(B) Amount Paid	1,045.51
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	277.89

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	R Stacy				6/1/03			
A	T Raquel		10/21/1983	full time 5/1/03	6/1/03		5C4	Part time
A	C Dilin		6/12/1982	02/23/03	4/1/03		4LV	Part time

K6-14514 04 N 70

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UG-000213

UNUM.

UNUM Life Insurance Company of America
Portland, Maine 04122-1570

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
010821		Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
K	Dustin	John	

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked
06 / 12 / 1980	02 / 11 / 2003	☐ F ☑ M	$11.50	☐ Weekly ☐ Monthly ☐ Annually	Weekly 40

11. Occupation/Title

12. Your employer will inform you of available coverages. Check yes to enroll.
Check no if you decline or coverage is not available.

Life/AD&D	☑ Yes	☐ No	LTD	☐ Yes	☐ No
STD	☐ Yes	☐ No	Dependent Life	☑ Yes	☐ No

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature [signature] Date: 5 / 18 / 03

16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	___/___/_____	____ STD	___/___/_____
____ Dep Life	___/___/_____	____ LTD	___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/96) EMPLOYEE COPY

REDACTED

UNUM

UNUM Life Insurance Company of America
Portland, Maine 04122-1870

Group Enrollment Form

1. Policy	2. Division #	3. Policyholder's Name
0108121		Site for Sore Eyes

4. Employee's Last Name	First	Middle Initial	5. Social Security Number
T	Raquel	E.	

6. Birthdate	7. Employment Date	8. Sex	9. Salary		10. Hours Worked
02/1/1983	10/06/2000	☒ F ☐ M	$ 12.60	☐ Weekly ☐ Monthly ☐ Annually	Weekly 40

11. Occupation/Title: Receptionist

12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.

Life/AD&D	☐ Yes ☐ No	LTD	☐ Yes ☒ No		
STD	☐ Yes ☐ No	Dependent Life	☐ Yes ☐ No		

13. Beneficiary(ies) Last Name	First	Middle Initial	14. Relationship
T.	Raquel	Elena	Dau

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that UNUM may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature: Raquel T. Date: 10/6/00

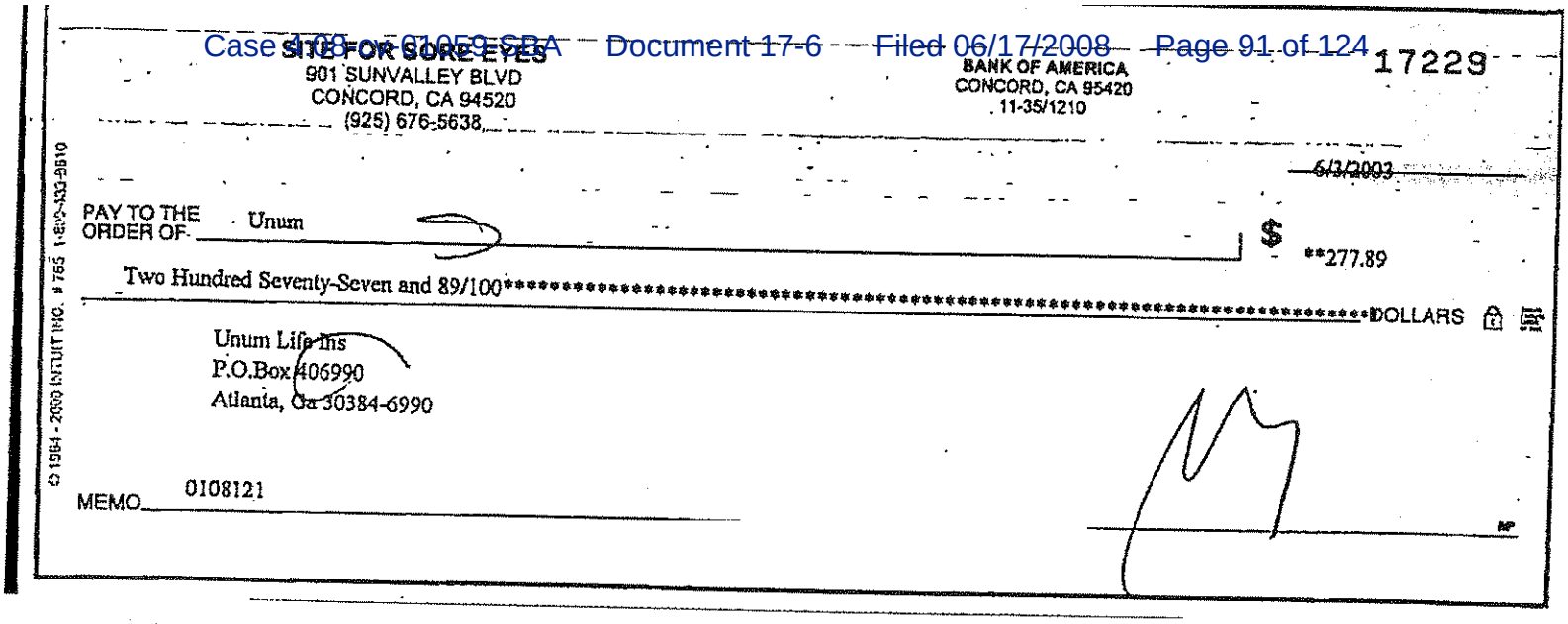
16. For UNUM Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	___/___/_____	____ STD	___/___/_____
____ Dep Life	___/___/_____	____ LTD	___/___/_____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1002-91 (2/98) EMPLOYEE COPY

REDACTED



SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

17229

6/3/2003

PAY TO THE ORDER OF Unum

$ **277.89

Two Hundred Seventy-Seven and 89/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

© 1994 - 2000 INTUIT INC. # 765 1-800-433-8810

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UnumProvident
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02219

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	317.87
Policy No. 0108121	Division No. 001 4
Due Date 07/01/2003	Statement Date 06/09/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

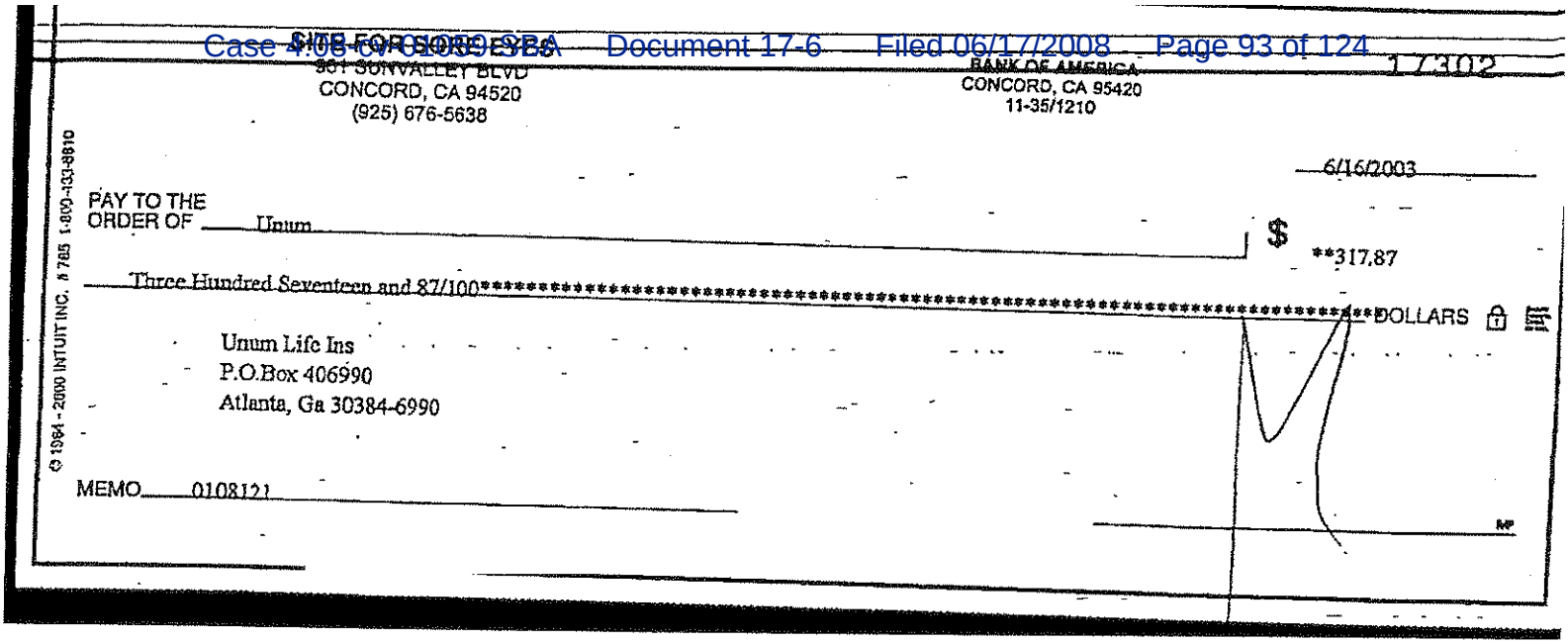
Current Period Premium		292.46
Adjustments to Prior Period's Premium		25.41
Prior Period		
(A) Amount Billed	277.89	
(B) Amount Paid	277.89	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		317.87

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14514 04 N 70

Please remit this page with your payment.


[redacted]
301 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638
BANK OF AMERICA
CONCORD, CA 95420
11-35/1210
17302
6/16/2003
PAY TO THE ORDER OF Unum
$ **317.87
Three Hundred Seventeen and 87/100********** DOLLARS
Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990
MEMO 0108121
© 1994 - 2000 INTUIT INC. # 785 1-800-133-8810

REDACTED

EXHIBIT OO

UNUM PROVIDENT
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02950

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	292.46
Policy No. 0108121	Division No. 001 4
Due Date 08/01/2003	Statement Date 07/10/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium		292.46
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	317.87	
(B) Amount Paid	317.87	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		292.46

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	Michael T.				7/12/03			

K6-14515 04 N 70

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SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

17391

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

7/14/2003

PAY TO THE ORDER OF Unum $ **292.46

Two Hundred Ninety-Two and 46/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

EXHIBIT PP

UnumProvident

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02847

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	239.96
Policy No. 0108121	Division No. 001 4
Due Date 09/01/2003	Statement Date 08/11/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period Premium	266.21
Adjustments to Prior Period's Premium	-26.25
Prior Period	
(A) Amount Billed	292.46
(B) Amount Paid	292.46
Balance from Prior Period (A-B)	
TOTAL PREMIUM DUE	239.96

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
A	S Maria		05/03/56	6/1/03				480 per week

K6-14515 04 N 70

Please remit this page with your payment.

REDACTED

SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

17441

8/8/2003

PAY TO THE ORDER OF Unum $ **239.96

Two Hundred Thirty-Nine and 96/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

UnumProvident
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02913

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	400.41
Policy No. 0108121	Division No. 001 4
Due Date 10/01/2003	Statement Date 09/09/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520-

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

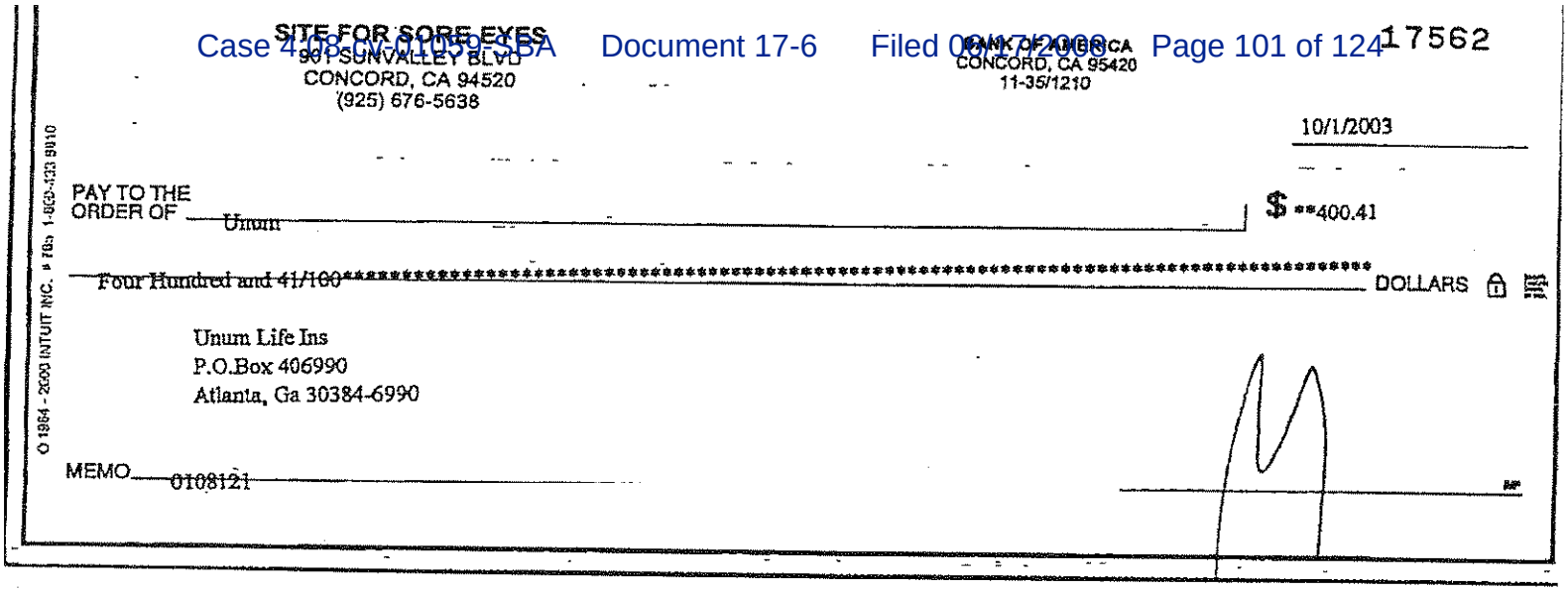
Current Period Premium		299.76
Adjustments to Prior Period's Premium		100.65
Prior Period		
(A) Amount Billed	239.96	
(B) Amount Paid	239.96	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		400.41

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary

K6-14515 04 N 70

Please remit this page with your payment.



SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

17562

10/1/2003

PAY TO THE ORDER OF Unum

$ **400.41

Four Hundred and 41/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

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REDACTED

UnumProvident

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

02022

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	299.76
Policy No. 0108121	Division No. 001 4
Due Date 11/01/2003	Statement Date 10/10/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☐

SUMMARY OF PREMIUMS DUE

Current Period-Premium		299.76
Adjustments to Prior Period's Premium		
Prior Period		
(A) Amount Billed	408.41	
(B) Amount Paid	408.41	
Balance from Prior Period (A-B)		
TOTAL PREMIUM DUE		299.76

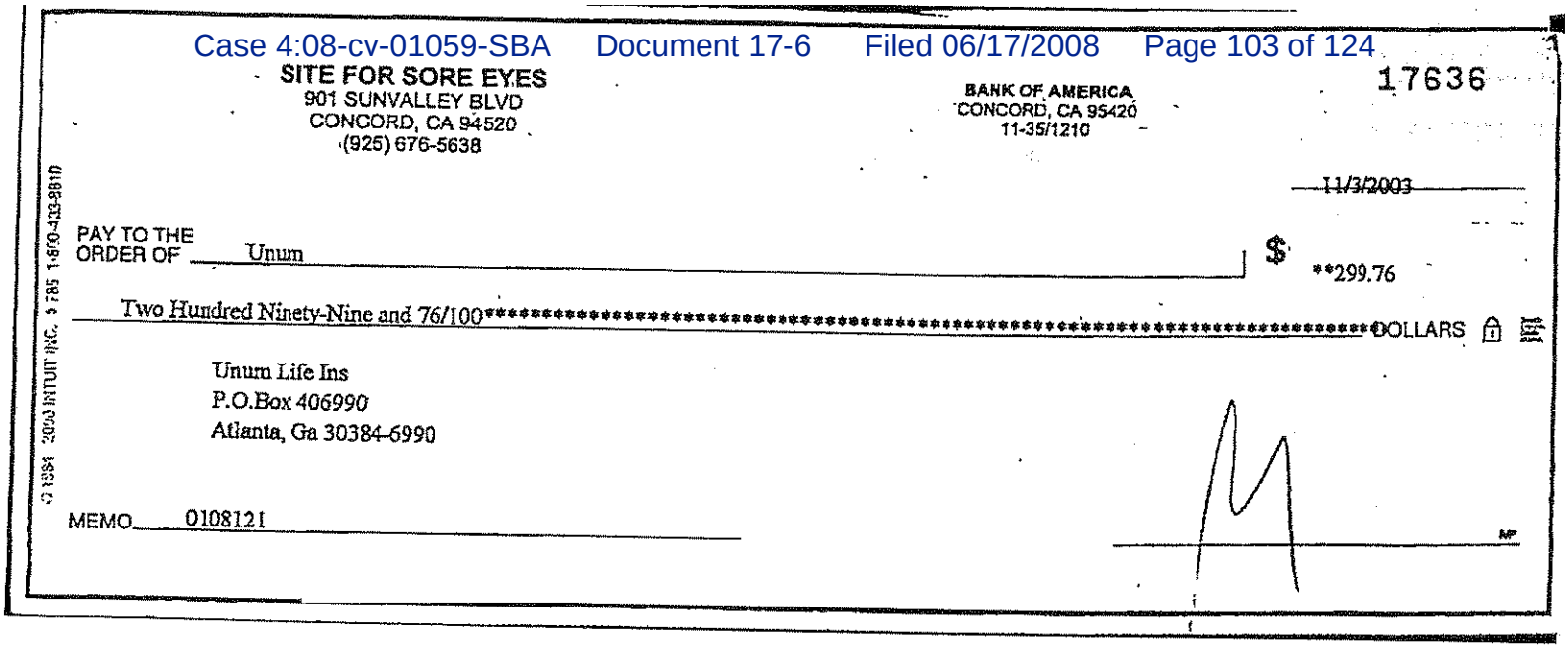
Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	S. Maria				11/1/03			

K6-14515 04 N 70

Please remit this page with your payment.

REDACTED



SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

17636

11/3/2003

PAY TO THE ORDER OF Unum

$ **299.76

Two Hundred Ninety-Nine and 76/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

MP

REDACTED

UNUMPROVIDENT

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

03545

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	599.52
Policy No. 0108121	Division No. 001 4
Due Date 12/01/2003	Statement Date 11/10/2003

SHERI GARAY
SHERI A. GARAY DBA
SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

Please pay as billed. Adjustments for changes received prior to the statement date are reflected on this bill.

For billing questions, please call (800) 421-0344

Fax Instructions:

Our fax number is (207) 771-4018. Additions / Changes may be faxed to expedite adjustments to your next bill. (Please continue to return this form with your premium payment.)
Please check here if faxed ☒

SUMMARY OF PREMIUMS DUE

Current Period Premium	299.76
Adjustments to Prior Period's Premium	
Prior Period (A) Amount Billed 299.76 (B) Amount Paid	
Balance from Prior Period (A-B)	299.76
TOTAL PREMIUM DUE	599.52

Addition - All Fields
Salary Change - Name, Effective Date, Salary and SSN
Termination - Name, Last Day Worked (Effective Date) and SSN
Reinstatement - All Fields
Class Change - Name, Effective Date, Class and SSN
Other Change

Type	Employee Name (last, first, middle initial)	Social Security Number	Date of Birth	Date of Hire	Effective Date	Dep Y/N	Class	Salary
T	S Maria	no longer here			7/30/03			

K6-14515 B4 N 78

Please remit this page with your payment.

REDACTED

SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

17671

11/23/2003

PAY TO THE ORDER OF Unum $ **266.21

Two Hundred Sixty Six and 21/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

UNUMPROVIDENT
Unum Life Insurance
Company of America
2211 Congress Street
Portland, Maine 04122

02523

Group Insurance Premium Statement

Please Remit To:

UNUM LIFE INSURANCE
COMPANY OF AMERICA
PO BOX 406990
ATLANTA GA 30384-6990

TOTAL PREMIUM DUE	221.81
Policy No. 0108121	Division No. 001 4
Due Date 01/01/2004	Statement Date 12/10/2003

SHERI GARAY
SHERI A. GARAY DBA
~~SITE FOR SORE EYES~~
901 SUNVALLEY BLVD
CONCORD CA 94520

Fold

17721

SITE FOR SORE EYES
901 SUNVALLEY BLVD
CONCORD, CA 94520
(925) 676-5638

BANK OF AMERICA
CONCORD, CA 95420
11-35/1210

12/6/2003

PAY TO THE ORDER OF Unum $ **221.81

Two Hundred Twenty-One and 81/100********** DOLLARS

Unum Life Ins
P.O.Box 406990
Atlanta, Ga 30384-6990

MEMO 0108121

REDACTED

EXHIBIT QQ

UNUMPROVIDENT

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)
Mail to: UnumProvident, Glendale Customer Care Center, 655 North Central Ave, Suite 800, Glendale, CA 91203
Claim Questions: 877.851.7637 **Fax To:** 877.851.7624

RECEIVED VIA USPS JUN 19 2002 GLENDALE CCC

B. CLAIMANT'S STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

☐ Short Term Disability ☐ Long Term Disability ☐ Individual Disability ☐ Waiver of Premium (Life Insurance) ☐ Voluntary Benefits/Payroll Deduction

Policy Numbers: | The State in which You Work: CA

1. Claimant's Name: Sheri Garay

Home Address (Street, City, State, Zip): Walnut Creek CA 94598

Home Phone Number | Date of Birth | Social Security Number | ☐ Male ☑ Female

2. Is this condition due to ☐ Accident ☐ Sickness? | Is this disability related to your employment? ☐ Yes ☑ No

Describe the injury incurred (what, how, where, when) or the nature and details of the sickness and when it began:
Degenerative Spine disease

You have been unable to work because of this condition as of what date? September 3, 2001

3. Employer's Name and Address: Site for Sore Eyes 901 Sunvalley Blvd

Claimant's Work Phone Number	Occupational Title	List the duties of your occupation at the time of your disability. Duty	# of weekly hours spent at duty
(925) 676-5638	Optician	Sales	
Have you returned to work? If yes, When? Part Time: 6/10/02 Full Time:			
Hours per week:			
If you have not returned to work, when do you expect to return? Part Time: Full Time:			

How does your injury or sickness impede your ability to do your occupational duties?
Yes

4. Information about physicians and hospitals
NOTE: TO AVOID DELAY IN EVALUATING YOUR CLAIM, ADVISE YOUR DOCTOR(S) TO ATTACH COPIES OF MEDICAL RECORDS AND TEST RESULTS.

First medical attention for the current disability was given by (complete below):

Doctor's Name: JASON A. Smith, M.D. | Doctor's Specialty: Spine Surgery
Address (Street, City, State, Zip): 2405 Shadelands Dr. Walnut Creek, Ca. 94598 | Phone Number: (925) 939-8585
Hospital Name: John Muir Medical Center | Hospital Phone Number: (925) 939-3000
Address (Street, City, State, Zip): 1601 Ygnacio Valley RD Walnut Creek, Ca. 94598
Dates of Confinement: From: 04-01-02 To: 04-04-02 From: To:

If other doctors or hospitals were consulted in the last five years, please attach a separate sheet of paper.

5. Marital Status:	If you are married: Spouse's Name	Spouse's Date of Birth	Is Spouse Employed?
☐ Single ☐ Married ☐ Widowed ☑ Divorced			☐ Yes ☐ No

List your children who are under age 25: (*Please attach additional sheets if necessary).

Name	Date of Birth	Married?	Attending High School?
Marisa Garay	7/29/82	☐ Yes ☑ No	☐ Yes ☑ No
Alana Garay	9/9/81	☐ Yes ☑ No	☐ Yes ☑ No

6. If you have been approved or denied for any of these benefits, please send a copy of Award or Denial Notification.
(Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.)

Social Security/Retirement	☐ Yes ☑ No	Social Security/Disability	☐ Yes ☑ No	Canada Pension Plan	☐ Yes ☑ No	State Disability	☐ Yes ☑ No
Worker's Compensation	☐ Yes ☑ No	Pension/Retirement	☐ Yes ☑ No	Pension/Disability	☐ Yes ☑ No	Unemployment	☐ Yes ☑ No
No-Fault Insurance	☐ Yes ☑ No	Short Term Disability	☐ Yes ☑ No – Ins. Co. Name and Policy #				
Other (Include Individual Disability or Group Disability Benefits)			☐ Yes ☑ No – Ins. Co. Name and Policy #				

7. If your request for benefits is approved, do you want Federal Income Tax Withheld from your check? ☑ Yes ☐ No
If yes, please indicate dollar amount $ (Note: Minimum withholding is $20.00 per week or $87.00 per month)
Do you want State Income Tax withheld from your check? ☑ Yes ☐ No
If yes, please indicate dollar amount $ (Note: The amount indicated must be a whole dollar increment)

REDACTED

UACL00017

UNUMPROVIDENT

DISABILITY CLAIM CLAIMANT'S AUTHORIZATION

Mail to: UnumProvident, Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 91203
Claim Questions: 877.851.[illegible]7 Fax To: 877.851.7624

FOR CLAIMANT TO COMPLETE

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Colorado Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning for District of Columbia, Maine and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of me, my health (including any disorder of the immune system including HIV or AIDS, any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings, employment history or other insurance benefits, to release such information to any of the UnumProvident Corporation subsidiaries or their duly authorized representatives. I also authorize the UnumProvident Corporation subsidiaries to request a report from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record System (DIRS). I understand that the dates of my past and present claims with any of the UnumProvident Corporation subsidiaries, excluding medical or personal information, may be reported to MIB and that an HCI or DIRS report may reflect this information including the identity of other insurance companies to which I have submitted claims. I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits.

This authorization is valid for the duration of my claim. I know that I or my authorized representative has a right to request a copy of this authorization. A copy of this authorization shall be as valid as the original.

I further authorize the UnumProvident Corporation subsidiaries or other authorized representatives to release all information (including information pertaining to HIV or AIDS, mental illness, and drug and alcohol abuse) related to this insurance claim to insurance companies, third party administrators, physicians, rehabilitation professionals, vocational evaluators, employers, my insurance agent, and any institution or person on a need to know basis for the purpose of verifying, evaluating, negotiating, or other pertinent uses with respect to my claim for benefits or service.

The statements made by me on this claim are true and complete.

I further authorize the UnumProvident Corporation subsidiaries or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

I am the individual to whom this release/request applies or that person's legal Guardian, Power of Attorney, or Conservator. I know that if I make any representation which I know is false to obtain information from federal records, I could be punished by fine or imprisonment or both.

Signature of Claimant X

Please Print Name

Date Signed Social Security Number

I signed on behalf of the claimant, as _____(indicate relationship). If Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.

Claimant Name: Sheri Garay Claim #: 322239

1321-99 (6/01)

UACL00018

REDACTED

UnumProvident

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)
Mail to: UnumProvident, Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 91203
Claim Questions: 877.851.7637 **Fax To:** 877.851.7624

RECEIVED VIA USPS JUN 19 2002 GLENDALE CCC

C. EMPLOYMENT STATEMENT (continued)

10. Date of last Salary/Wage increase N/A | Work Schedule at time last worked: N/A Days/Week Hours/Day Hours/Week

Check off regular work days: ☐ Sun ☑ Mon ☑ Tues ☑ Wed ☑ Thurs ☑ Fri ☑ Sat. | Number of hours on date last worked:

Date paid through: N/A For: ☐ Salary Continuation ☐ Vacation Pay ☐ Accrued Sick Pay ☐ Other

11. Has claimant returned to work? ☒ Yes ☐ No If yes, date: ☐ Full Time ☒ Part Time 15 Hours Per Week

12. Does the claimant have an ownership interest in this business? ☒ Yes ☐ No If yes, what is the % of ownership? 100 %
Type of business entity? ☐ Regular Corporation ☐ S corporation ☐ Partnership ☒ Sole Proprietorship

13. If this is a Flexible Benefits Plan, indicate which option of coverage this claimant has chosen.
Previous Plan Year - Date of Open Enrollment: Option Current Plan Year - Date of Open Enrollment: Option

14. Prior LTD Carrier Name: None | Effective Date

Address (Street, City, State, Zip) | Termination Date

15. Is claimant eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	☐	☒	$	☐	☐		
State Disability	☐	☒	$	☐	☐		
Other Disability Benefits	☐	☒	$	☐	☐		
Social Security	☐	☐	$	☐	☐		
Worker's Compensation	☐	☒	$	☐	☐		

Is the claim the result of a work related injury or sickness? ☐ Yes ☒ No

If so has Workers' Compensation claim been filed?	☐	☒	If yes, Name and Address of Carrier
Health Insurance	☒	☐	If yes, Name and Address of Carrier Blue Shield of California
Life Insurance	☐	☒	If yes, please provide the amount of coverage: $

If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

16. If New York DBL or New Jersey TDB applies, complete this question.

Earnings 8 weeks prior to disability

	Week Ending Mo.	Day	Yr.	No. Days Worked	Amount		Week Ending Mo.	Day	Yr.	No. Days Worked	Amount
1						5					
2						6					
3						7					
4						8					

17. Information about your pension plan (Please send copy of Plan Summary) (Do not complete for maternity claim)

Do you have a pension plan? ☒ Yes ☐ No | If yes, what type? ☐ Defined benefit ☐ Defined contribution ☐ 401(k)/403(b) ☒ Profit Sharing ☐ Other: (specify)

Is claimant eligible for your pension plan? ☐ Yes ☒ No | If eligible, does the claimant participate? ☐ Yes ☐ No | What % does claimant contribute?

If the claimant is participating, when is he or she eligible for benefits under the plan?

UACL00019

FRAUD NOTICE:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim.

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form	Telephone Number ( )
Title of Person Completing Form	Fax Number ( )
Signature	Date Signed

UNUMPROVIDENT

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)
Mail to: UnumProvident, Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 9120[illegible]
Claim Questions: 877.851.7[illegible] **Fax To:** 877.851.7624

C. EMPLOYMENT STATEMENT (PLEASE PRINT)

Type of Coverage (CHECK ALL THAT APPLY)

☐ Short Term Disability ☒ Long Term Disability ☐ Individual Disability ☐ Waiver of Prem[illegible] (Life Insurance) ☐ Voluntary Benefits/Payroll Deduction

1. Employer Name: Site for Sore Eyes — Employer's Phone Number: (925) 676-1638

Employer Address (Street, City, State, Zip): 901 Sunvalley Blvd Concord CA 94520

Policy Numbers: 108121 | Division Number / Cla[illegible]mber | Division / Class Description

2. Claimant's Name: Sheri Garay

Claimant's Address (Street, City, State, Zip)

Claimant's Home Phone	Date of Birth	Social Security Number	Date [illegible]	Effective Date of Insurance	Date Last Worked
			7/1 [illegible]9	10/1/1995	

Claimant's Work Status: ☐ Full Time ☐ Part Time ☐ Exempt ☐ Non-exempt ☐ Ba[illegible] ☐ Non-Bargaining

Has the claimant's employment been terminated? ☐ Yes ☒ No If yes, please provide term[illegible]n date:

General Information About the Claimant's Job

3. Job Title: Optician — Minimum education or training required:

Does the claimant perform supervisory function? ☒ Yes ☐ No | If yes, how many people are [illegible]pervised? 10

4. Describe job duties:

Duty	# of Weekly Hours Spent at Duty
Sales, fitting, measuring Eyewear	60
Dispensing glasses & Contacts	10
managing Employees, training	5
Accounts receivable + payable	10

Name of Direct Supervisor | Telephone Number of Direct Supervisor ( )

Please attach a copy of the claimant's job description.

5. How was claimant paid? (please check one)
☐ Hourly ☐ Commissions ☐ Salaried ☐ Salary and Bonus ☐ Commissions Only ☐ [illegible]y and Commissions

What is the earnings figure you use to compute premium payments for this claimant? $ to be determined

Salary/Wage prior to date last worked ***(refer to Earnings definition in your contract).***

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	Bonuses (per week)	Overtime (prior year	Commissions (per week)	W-2 Earnings
$	$	$	$	$

6. Does the claimant contribute toward the premiums? (Complete all that apply)

STD:	☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:	[illegible]50	% paid by employer	% paid by claimant
State Plans:	☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:		% paid by employer	% paid by claimant
LTD:	☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:		% paid by employer	% paid by claimant
IDI:	☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:		% paid by employer	% paid by claimant
Life:	☐ Yes ☐ No: If yes: ☐ Pre-Tax ☐ Post-Tax If Post Tax:		% paid by employer	% paid by claimant

7. Year to Date Earnings as of Date of Disability (For FICA % Deductions) $ To be determined

8. **Financial Documentation** (please refer to your contract for your Earnings definition and attach the appropriate documentation).
Salary Only/Current Earnings definition: Attach copy of payroll records or paystubs for 2 periods just prior to disability.
Bonus/Commissions Included: Attach copy of payroll records for the 12 or 24 months (see definition) just prior to disability.
Other Earnings definitions: Attach referenced document per Earnings definition (W-2, K-1's, Sch[illegible]le C's, teacher's contract, etc.).

9. Claimant Pre-Tax Withholdings: Indicate pre-tax withholdings in effect just prior to disability:
401(k)/403(b) %; Pre-tax medical and other insurance $ /week Flexible spending account $ /week

UACL00020

REDACTED

UNUMPROVIDENT

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)
Mail to: UnumProvident, Glendale Customer Care Center, 655 North Central Ave., Suite 800, Glendale, CA 91203
Claim Questions: 877.851.7637 **Fax To:** 877.851.7624

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

1. Name of Patient	Date of Birth	Social Security Number
Sheri Garay		

2. Diagnosis - Please include the primary diagnosis and list any secondary conditions.

Date of Last Examination	Diagnosis (including any complications) include ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number
5-30-02	Herniated Cervical Discs 722.0

Objective findings (including current x-rays, EKGs, pyschiatric testing, laboratory data and any clinical findings)
(+) MRI

Symptoms ↓ ROM bilateral arm radiculopathy

Is this condition due to ☐ an Accident ☐ a Sickness? | Date symptoms first appeared or accident occurred: Chronic

Is the accident or sickness related to the patient's employment? ☐ Yes ☐ No ☐ Unknown

Date restrictions and limitations began: 9-5-01 | Has patient ever been treated for the same or similar condition? ☐ Yes ☒ No If yes, state when and describe.

3. Information About the Patient's Ability to Work - this information is critical to understanding your patient's condition

Has patient been released to work in his/her occupation? ☐ Yes ☒ No In any ocupation? ☐ Yes ☒ No

If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below.

Fully describe restrictions and limitations.
RESTRICTIONS (What the patient should not do) No overhead lifting, bending, twisting

LIMITATIONS (What the patient cannot do) Same as above - Cannot be with out cervical collar post operatively - No neck motion

When should the patient be able to return to work? Full Time: 10-1-02 Part Time:

Height/Weight	Blood Pressure Last Visit	If Pregnancy, Expected Delivery Date	If Delivered, Actual Delivery Date	Delivery Type
5'4" 113	WNL 92/62			☐ Normal ☐ C-Section

Date of first visit for this illness or injury	Date of next visit	Date of last visit	Frequency of visits
9-5-01	6-15-02	5-30-02	Monthly

Is patient: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☒ Hospital Confined

Has patient been admitted to hospital? ☒ Yes ☐ No Confined From: 04-01-02 To 04-04-02

If Hospital Confined, give name and address of hospital John Muir Medical Center 1601 Ygnacio Valley Rd Walnut Creek.

Have you completed claim forms regarding this patient for other insurance carriers? ☐ Yes ☒ No If yes, state date and name of insurance company:

4. Names and Addresses of Other Treating Physicians

Referring physician or other treating physicians (names, address, phone #'s):

UACL00021

REQUIRED ATTACHMENTS AND SIGNATURES
Please make sure that office notes, test results, and discharge summaries are attached. This will help reduce additional requests.
FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.
The above statements are true and complete to the best of my knowledge and belief.

Print or Type Name	Degree	Medical Specialty
JASON A. Smith M.D	M.D.	Spine Surgery

Street Address		Phone Number
2405 Shadelands Dr. #1		(925) 939-8585
City	**State** / **Zip Code**	**Fax**
Walnut Creek Ca.	94598	(925) 933-6939

Signature of Physician [signature] Date 5/31/02

SSN or Employer's ID Number: 94-3375456

Claimant Name: Sheri Garay Claim #: 322239

1321-99 (6/01)

REDACTED

UNUMPROVIDENT

CLAIM FOR DISABILITY BENEFITS

UnumProvident, Glendale Customer Care Center, 655 North Central Ave., Suite 800,
Glendale, CA 91203
Phone: 877.851.7637 Phone: 877.851.7624

For use with policies issued by the following UnumProvident Corporation ["UnumProvident"] subsidiaries:

Unum Life Insurance Company of America
First Unum Life Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

Please mail or fax this form to:
UnumProvident
Glendale Customer Care Center
655 North Central Ave., Suite 800 Glendale, CA 91203
Toll free 877.851.7637 Fax 877.851.7624

This form must be completed by the Attending Physician, the Claimant, and the Employer (for employer-sponsored policies), and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please be sure to keep a copy of this form and any attachments for your records.

The claimant is responsible for completion of all portions of this form without expense to the UnumProvident Corporation subsidiaries.

INSTRUCTIONS:

A. **Attending Physician's Statement:** This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of treatment are indicated in this section and that your physician personally signs and dates this claim form.

B. **Claimant's Statement:** This section must be completed by you, the claimant. Please make sure you sign and date the bottom of the authorization page after you complete your section.

C. **Employment Statement:** Group Sponsored Policies - The employer must complete this form. Individual Policies - Please refer to the attached Instructions Sheet.

Please enclose any additional information that you feel will assist us in evaluating this claim.

UACL00022

EXHIBIT RR

ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement ("Agreement"), dated as of this 9th day of January, 2004, is entered into between Sheri Garay (the "Seller") and New Age Optical, Inc. a California corporation (the "Buyer").

RECITALS

A. WHEREAS, Seller is the owner and operator of a Site for Sore Eyes franchise (the "Business"), operated at 901 Sun Valley Boulevard, Concord, California (the "Premises").

B. WHEREAS, Seller desires to sell the Business and Buyer desires to purchase the Business from Seller, on the terms and conditions set forth herein.

Accordingly, the parties agree as follows:

3. Sale of Assets.

Assets to be Sold.

Except for the "Excluded Assets" described in Section 1.2, on the Closing Date (as defined in Section 4 below), Seller shall sell, assign, transfer and deliver to Buyer all of the assets, properties and rights of the Business of every type and description, personal and mixed, tangible and intangible, wherever located and whether or not reflected on the books and records of the Business, relating to or used or employed in connection with the Business as they exist on the Closing Date (all of such assets, properties, rights and business being hereinafter sometimes collectively called the "Purchased Assets"), including, without limitation:

(i)all of the stock and trade and merchandise of the Business, including raw materials, work in progress and finished goods (the "Inventory");

(ii)all tangible assets used in connection with the Business, wherever located, including furniture, fixtures and equipment, other than the Excluded Assets (defined below);

(iii)all Assumed Agreements (as defined in Section 2.1(iv);

(iv)all of Seller's right in the names "Site for Sore Eyes" and all variants thereof and all names and marks similar thereto, which names are a complete list of the names used by Seller in connection with the Business;

(v)all websites, trade secrets, proprietary information, software and computer programs necessary for Seller to conduct its Business (collectively, the "Technology");

(vi)all diskettes, user manuals, databases, originals of customer contracts, copies of customer correspondence;

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Claimant Name: Sheri Garay Claim #: 1081100

(vii)all lists of prospects, customers, suppliers and promotions; and

(viii)all of the goodwill of the Business.

In confirmation of the foregoing sale, assignment and transfer, Seller shall execute and deliver to Buyer at the Closing a Bill of Sale and Instrument of Assumption in the form of Exhibit A and such other instruments and assignments as may be necessary to convey to Buyer good title to the Purchased Assets.

Excluded Assets. Notwithstanding any other provision of this Agreement, Seller shall retain and shall not transfer to Buyer the following assets: (i) all accounts receivables due and owing for products and services sold (to the extent such services are actually performed), (ii) cash and cash equivalents, (iii) bank accounts and insurance proceeds for claims arising prior to the Closing Date and (iv) all assets set forth on Schedule 1.2 hereto (collectively, all assets referred to in subsections (i), (ii), (iii) and (iv) shall be referred to herein as the "Excluded Assets").

1.Assumption of Liabilities.

Liabilities Assumed by Buyer.

From and after the Closing Date, Buyer shall assume, pay, perform and discharge all of Seller's liabilities with respect to:

Inventory ordered for the Business prior to the Closing Date but not received by the Business as of the Closing Date;

(i)claims for refund or exchange, or for store credit, made by customers of the Business after the Closing Date relating to purchases from the Business on or prior to the Closing Date;

(ii)all gift certificates issued by the Business prior to the Closing Date (with (i) through (iii) collectively referred to as the "Assumed Liabilities"); and

(iii)all right, title and interest in and claims under those contracts, agreements, licenses and commitments, real property leases and personal property leases used in or relating to the Business (the "Assumed Agreements"), including, without limitation, (A) the Sterling Optical Center Franchise Agreement for the State of California, dated June 1, 1999 with respect to a franchise under the trade name Site for Sore Eyes Optical Centers or Sterling Optical Centers (the "Franchise Agreement"), (B) that certain Professional Center at Sun Valley Site For Sore Eyes Lease for 1003 Willow Pass Road, Concord, California (currently known as 901 Sun Valley Boulevard, Concord, California), dated October 6, 1986 by and between Professional Center Sun Valley, Inc., predecessor-in-interest to CCB Bancorp, a California banking corporation, and Site for Sore Eyes Opticians, a California corporation, predecessor-in-interest to Seller, as amended (the "Store Lease"), and (C) that certain lease for the Optical Dynamics lens crafting machine by and between Seller and Popular Leasing, Lease No. 09435.

2.Consideration and Payment.

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5.2Buyer has been given adequate access to the Business, Purchased Assets and Seller's records concerning the Business and the Assumed Liabilities, and agrees that Buyer has entered into this Agreement as a result of such inspections and investigations as Buyer deems appropriate, and not as a result of any representations by Seller or any agent or representative of Seller which are not set forth in this Agreement;

5.3Buyer has not retained any broker or finder in connection with the transaction contemplated by this Agreement; and

5.4Promptly after the execution hereof, Buyer shall submit to Sterling Vision, Inc. all necessary documents and the franchise transfer fee so as to permit approval of Buyer as the transferee of the Franchise Agreement.

6.Covenants and Agreements.

Expenses of Sale and Taxes.

Each party shall pay its own legal and accounting expenses incurred in negotiating, executing and performing this Agreement; provided, that Buyer shall pay all costs and expenses associated with the escrow account. California sales tax, if any, resulting from the sale of the Purchased Assets shall be the sole responsibility of Buyer to pay and report.

Employees.

As of the Closing Date, all employees of the Business shall be terminated by Seller.

Access to Records.

Seller agrees to provide Buyer with reasonable access to the books and records of the Business after the Closing Date for the purpose of preparing tax returns, defending claims or other reasonable business purposes.

Ordinary Course.

Through the Closing Date, Seller shall carry on the Business in the ordinary course in substantially the same manner as heretofore conducted and shall refrain from selling, leasing, licensing or otherwise disposing of, creating or imposing any encumbrance on any of the Purchased Assets of the Business, other than in the ordinary course consistent with past practices.

Confidentiality.

No party shall divulge, communicate, use to the detriment of any other party or for the benefit of any other person or persons, or misuse in any way, any other party's confidential information discovered or disclosed as a result of the delivery, execution or performance of this Agreement.

Further Assurances.

Balance of Sale agreement 1

Buyer or in any way interfere with its relationship with Buyer; or (c) hire, retain or attempt to hire or retain any employee of Buyer; provided, however, any acceleration of the Notes due to an event of default by Buyer shall terminate any and all of Seller's obligations pursuant to this Section 7.10.

7. Conditions to Closing.

Conditions Precedent to the Obligations of Buyer.

The obligations of Buyer to complete the Closing are subject to the fulfillment on or prior to the Closing Date (or such other date as may be specified) of the following conditions, any one or more of which may be waived by Buyer:

(i) Seller shall have executed and delivered to Buyer the Bill of Sale and Instrument of Assumption;

(ii) the representations and warranties made by Seller in Section 5 shall be true and correct in all material respects;

(iii) Seller shall have materially complied with all covenants contained in this Agreement;

(iv) Sterling Vision, Inc. shall have consented in writing to the assignment of the Franchise Agreement by Buyer;

(v) The acquisition of the Purchased Assets shall be pursuant to a bulk sale escrow conducted in accordance with Division 6 of the California Commercial Code, with escrow to be opened at Commercial Escrow Services, Inc. ("Escrow Holder"), Antoinette Hardstone, Escrow Officer. The parties shall sign customary escrow instructions in the form maintained by the Escrow Holder for transactions of the type contemplated by this Agreement. Seller shall furnish to Buyer a true and complete list of all business names and addresses used by Seller within three years before the date such list is sent or delivered to Buyer, as provided in Section 6104 of the Uniform Commercial Code-Bulk Sales, of the State of California ("Section 6104"). Buyer shall give notice of the sale of the Purchased Assets in accordance with Section 6104. Seller agrees to take all actions reasonably requested by Buyer in order to effect compliance with Section 6104, and similar laws of other jurisdictions applicable to bulk transfers or concerning fraudulent transfers, as may be required with respect to the transfer of the Purchased Assets; and

(vi) Bowie, Bruegman and Eztrol (the "Landlord") shall have consented in writing to the sublease of the Premises to Seller for the remainder of the term of the Store Lease.

Conditions Precedent to the Obligations of Seller.

The obligations of Seller to complete the Closing are subject to: (a) Buyer's delivery of the cash portion of the Purchase Price to Seller; (b) Buyer's delivery of each of the executed Notes and the Security Agreement to Seller; and (c) the Landlord's written consent to release Seller from all obligations under the Store Lease after one (1) year from the date hereof.

(iii)all items deposited into escrow by Buyer shall be returned to Buyer; provided, however, Seller shall be entitled to two percent (2%) of the Escrow Deposit as liquidated damages as long as such termination is no fault of Seller, her agents, representatives or employees; and

(iv)Seller shall retain the Deposit.

10.Miscellaneous.

Confidentiality.

Seller and Buyer agree to keep the terms and conditions of this Agreement confidential except insofar as disclosure may be contemplated herein or may be required by law or regulation or legal process and in such event the party so required to disclose shall provide the other party with prompt notice to enable it to seek a protective order or other appropriate remedy preventing disclosure.

Notices.

Any notice or other communication required or which may be given hereunder shall be in writing and shall be delivered personally, sent by facsimile transmission or sent by certified, registered or express mail, postage prepaid, and shall be deemed given when so delivered personally, or sent by facsimile transmission or if mailed, five days after the date of mailing, as follows:

(i)if to Buyer, to:

New Age Optical, Inc.
901 Sun Valley Blvd.
Concord, CA 94520

with a copy to:

(ii)if to Seller, to:

Ms. Sheri Garay
Walnut Creek CA 94598

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Claimant Name: Sheri Garay Claim #: 1081100

REDACTED

UG-000245

Buyer acknowledges that the firm of Greene Radovsky Maloney & Share LLP is counsel to Seller and that such firm has not represented Buyer in connection with this Agreement and any other transaction or the execution of any other document contemplated in connection with any of the foregoing and that Buyer has been urged to seek, and hereby represents that Buyer has sought Buyer's own counsel in this matter.

Arbitration.

Each of the parties agrees that in the event of any controversy, dispute, or issue arising out of, in connection with, or in relation to, this Agreement, such dispute shall be resolved through neutral, binding arbitration and not by court action, except as provided by California law for judicial review of arbitration proceedings. The arbitration shall be conducted in accordance with the then current rules of commercial dispute resolution of JAMS/Endispute. The place of arbitration shall be in San Francisco, California. The arbitrator shall be empowered to make all necessary rulings. The arbitrator shall award reasonable attorneys' fees and costs to the prevailing party as part of the award. The award of the arbitrator shall be accompanied by a written statement of the basis for such award, shall be final and binding, and may be entered as a judgment in any court of competent jurisdiction. The parties shall select one arbitrator for this purpose who shall be a retired judge.

Attorneys' Fees.

If a party brings any legal action or arbitration regarding any provision of this Agreement, the prevailing party shall be awarded reasonable attorney's fees from the other party in addition to any other relief it may be granted.

No Third Party Beneficiaries.

Except as specifically set forth or referred to herein, nothing herein expressed or implied is intended or shall be construed to confer upon or give to any person or corporation other than the parties hereto and their successors or assigns any rights or remedies under or by reason of this Agreement.

[Remainder of Page Intentionally Left Blank.]

IN WITNESS WHEREOF, the parties have executed this Agreement on the date first above written.

SELLER:BUYER:

NEW AGE OPTICAL, INC., a California corporation

SHERI GARAY, an individual By: Nick Saab 12/8/03

Its: Secretary

By: Rabih Kantar 12/8/03

Its: President

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Claimant Name: Sheri Garay Claim #: 1081100

BILL OF SALE
AND
INSTRUMENT OF ASSUMPTION

BILL OF SALE AND INSTRUMENT OF ASSUMPTION (this "Agreement") made as of _____, 2003 by and between SHERI GARAY ("Assignor"), and NEW AGE OPTICAL, INC., a California corporation ("Assignee").

RECITALS

Assignor and Assignee are parties to that certain Asset Purchase Agreement dated _____, 2003 (the "Asset Purchase Agreement"), pursuant to which Assignor is selling certain of assets of the Business to Assignee, and Assignee is assuming certain of the liabilities of the Business, all as more specifically set forth in the Asset Purchase Agreement. The capitalized terms used herein and not otherwise defined herein shall have the meanings ascribed to them in the Asset Purchase Agreement.

NOW, THEREFORE, IT IS AGREED:

1. *Assignment.* For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Assignor hereby sells and assigns the Purchased Assets to Assignee, free and clear of all liens and encumbrances of any nature.

2. *Assumption.* Assignee hereby agrees to be bound by all of the terms of, and undertakes and assumes all of the obligations, duties, and liabilities of Assignor accruing under, the liabilities set forth in Section 2.1 of the Asset Purchase Agreement, including the Assumed Liabilities and the Assumed Agreements.

3. *Further Assurances.* Each party hereto shall, at any time and from time to time, upon the request of the other party hereto, promptly and duly execute and deliver any and all such further instruments and documents and take such further actions as the requesting party may reasonably request to fulfill the purposes of this Agreement.

Claimant Name: Sheri Garay Claim #: 1081100

UACL01597

IN WITNESS WHEREOF, the parties have executed this Agreement on the date first above written.

SELLER:BUYER:

NEW AGE OPTICAL, INC., a California corporation

SHERI GARAY, an individual By: Nick Saab 12/8/03

Its: Secretary

By: Rabih Kantar 12/8/03

Its: President